VI. Executive Orders12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated a "significant regulatory action" because it is economically significant, under section 3(f) of Executive Order 12866, based on the Preliminary Regulatory Impact Analysis (PRIA) presented below. As a result, the OMB has reviewed this proposed rule. The Department also has concluded that this proposed rule is a major rule under the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. § 801 et seq.).

Preliminary Regulatory Impact Analysis of the Proposed Revisions to the Companionship Regulations

Background

Under Executive Order 12866 (58 FR 51735, October 4, 1993), the Department must determine whether a regulatory action is "significant" and therefore subject to OMB review and the requirements of the Executive Order. Executive Order 12866 defines "significant regulatory action" as one that is likely to result in a rule that may have "an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local, or tribal governments or communities; create a serious inconsistency or otherwise interfere with an action taken or

planned by another agency; materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order." This proposed rule meets the criteria for a significant regulatory action because it is anticipated to have an annual effect on the economy of $100 million or more. As a result, the rule is submitted to OMB for review.

The provisions of the FLSA apply to all enterprises that have employees engaged in commerce or in the production of goods for commerce and have an annual gross volume of sales made or business done of at least $500,000 (exclusive of excise taxes at the retail level that are separately stated); or, are engaged in the operation of a hospital, an institution primarily engaged in the care of the sick, the aged, or the mentally ill who reside on the premises; a school for mentally or physically disabled or gifted children; a preschool, elementary or secondary school, or an institution of higher education (regardless whether such hospital, institution or school is public or private, or operated for profit or not); or, are engaged in an activity of a public agency.

There are two ways an employee may be covered by the provisions of the FLSA: 1) any employee of an enterprise covered by the FLSA is covered by the provisions of the FLSA, and 2) even if the enterprise is not covered, individual employees whose work engages the employee in interstate commerce or in the production of goods for commerce or in domestic service is covered by the provisions of the FLSA. Covered employers are required by the provisions of the FLSA to: 1) pay employees who are not exempt from the Act's requirements not less than the Federal minimum wage for all hours worked and overtime premium pay at a rate of not less than one and one-half times the employee's

regular rate of pay for all hours worked over 40 in a workweek, and 2) make, keep, and preserve records of the persons employed by the employer and of the wages, hours, and other conditions and practices of employment.

In 1974, Congress expressly extended FLSA coverage to "domestic service" workers performing services of a household nature in private homes not previously subject to minimum wage and overtime requirements. While domestic service workers are covered by FLSA minimum wage and overtime requirements even though they work for a private household and not a covered enterprise, Congress created exemptions from these requirements for casual babysitters and persons employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves.[5]

Need for Regulation and Why the Department is Considering Action:

In 1974, Congress extended coverage of the FLSA to many domestic service employees performing services of a household nature in private homes not previously subject to minimum wage and overtime pay requirements. Section 13(a)(15) of the Act exempts from its minimum wage and overtime pay provisions domestic service employees employed "to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary)." Section 13(b)(21) of the FLSA exempts from the overtime pay provision any employee employed "in domestic service in a household and who resides in such household."

Since the 1975 regulations were implemented, the home health care industry has evolved and expanded in response to the increasing size of the population in need of such

[5] 29 U.S.C. §§ 202(a), 206(f), 207(l), and 213(a)(15).

services, the growing demand for in-home care instead of institutional care for persons of all ages, and the availability of public funding assistance for such services under Medicare and Medicaid. As the industry has expanded, so has the range of tasks performed by workers providing companionship services. The range now includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and paramedical tasks (such as catheter hygiene or changing of aseptic dressings).[6] Public funding programs do not cover services such as social support, fellowship or protection.[7] According to the U.S. Department of Health and Human Services (HHS), "[s]imple companionship or custodial observation of an individual, absent hands-on or cueing assistance that is necessary and directly related to ADLs and IADLs, is not a Medicaid personal care service."[8]

The Department of Labor believes that the current application of the companionship services exemption in the home health care industry is not consistent with the original Congressional intent. The Department proposes to modify the definition of companionship services to exclude personnel who perform functions that require training in the performance of medically-related duties, and to provide only a 20 percent tolerance for intimate personal care services and related household work. As a result, to qualify for the companionship services exemption, workers must spend at least 80 percent of their time in activities that provide fellowship or protection. Those workers who are providing home health care services that exceed the 20 percent tolerance for intimate personal care

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[6] PHI, 2010a. Background Report on the U.S. Home Care and Personal Assistance Workforce and Industry (Forthcoming). P. 22.

[7] PHI, 2010a. p. 22.

[8] "Understanding Medicaid Home and Community Services: A Primer," Gary Smith, Janet O'Keefe, Letty Carpenter, Pamela Doty, Gavin Kennedy, Brian Burwell, Robert Mollica and Loretta Williams, George Washington University, Center for Health Policy Research, October 2000.

services and related household work must be paid in accordance with federal minimum wage and overtime requirements.

Objectives and Legal Basis for Rule

Section 13(a)(15) of the FLSA exempts from its minimum wage and overtime pay provisions domestic service employees employed "to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary)." Due to significant changes in the home health care industry over the last 36 years, workers who today provide in-home care to individuals are performing duties and working in circumstances that were not envisioned when the companionship services regulations were promulgated. Section 13(b)(21) provides an exemption from the Act's overtime pay requirements for live-in domestic workers. The current regulations allow an employer of a live-in domestic worker to maintain a copy of the agreement of hours to be worked and to indicate that the employee's work time generally coincides with that agreement, instead of requiring the employer to maintain an accurate record of hours actually worked by the live-in domestic worker. The Department is concerned that not all hours worked are actually captured by such agreement and paid, which may result in a minimum wage violation. The current regulations do not provide a sufficient basis to determine whether the employee has in fact received at least the minimum wage for all hours worked.

The Department has re-examined the regulations and determined that the regulations, as currently written, have expanded the scope of the companionship services exemption beyond those employees whom Congress intended to exempt when it enacted § 13(a)(15) of the Act, and do not provide a sufficient basis for determining whether live-in workers

subject to §13(b)(21) of the Act have been paid at least the minimum wage for all hours worked. Therefore, the Department proposes to amend the regulations to revise the definitions of "domestic service employment" and "companionship services," and to require employers of live-in domestic workers to maintain an accurate record of hours worked by such employees. In addition, the proposed regulation would limit the scope of duties a companion may perform, and would prohibit employees of third-party employers from claiming the exemption.

Summary of Impacts

The Department projects that the average annualized cost of the rule will total about $4.7 million per year over 10 years. In addition to the direct cost to employers of the rule, there are also transfer effects resulting from the rule. The primary impacts of the rule are income transfers to home health care workers in the form of: increased hourly wages to reach minimum wage (about $16.1 million in the first year, negligible thereafter); payment for time spent traveling between patients (average annualized value of $34.7 million per year); and payment of an overtime premium when hours worked exceed 40 hours per week. Because overtime payments depend on how employers adjust scheduling to eliminate or reduce overtime hours, the Department considered three adjustment scenarios resulting in payment of: 100 percent of current overtime hours worked (average annualized value of $180.7 million per year); 50 percent of current overtime hours worked (average annualized value of $90.4 million per year); or no payment of overtime. On the basis of previous evidence on the impact of overtime pay, the Department judges that overtime payments in the range of scenarios 2 and 3 are more likely than scenario 1.

Although the transfer of income to workers in the form of higher wages is not considered a cost of the rule from a societal perspective, higher wages do increase the cost of providing home health care services, resulting in the provision of fewer services. This reduction in the provision of services causes the market to function less efficiently, and this allocative inefficiency is a cost from a societal perspective. With a 3% real rate, the Department measures the range of average annualized deadweight loss attributable to this allocative inefficiency as $105,000 when no overtime pay adjustment is assumed, $36,000 when 50% of overtime pay is assumed to adjust and $3,000 when a 100% adjustment in overtime pay is assumed. The relatively small deadweight loss primarily occurs because the both the demand for and supply of home health care services appear to be inelastic—that is, the equilibrium quantity of companionship services is not very responsive to changes in price, possibly due to the importance of these services and the coverage of many companionship services by Medicare and Medicaid. Table 1 summarizes the projected costs, transfer effects and impacts of the proposed revisions to the FLSA.

Table 1. Summary of Impact of Proposed Changes to FLSA

				Average Annualized Value ($ mil.)	
	Year 1 ($ mil.)	**Years 2 - 10 ($ mil.)[a]**		**3% Real Rate**	**7% Real Rate**
Costs					
Regulatory Familiarization					
Agencies	$3.9	$0.3	$0.3	$0.7	$0.8
Families Hiring Self-employed	$6.0	$3.2	$4.0	$3.8	$3.9
Total Costs	*$9.9*	*$3.5*	*$4.4*	*$4.6*	*$4.7*
Transfers					
Minimum Wages (MW)					
to Agency-Employed Workers	$13.0	$0.0[b]	$0.0[b]	$1.5	$1.7
to Self-Employed Workers	$3.1	$0.0[b]	$0.0[b]	$0.4	$0.4

Travel Wages	$26.7	$27.8	$45.8	$35.4	$34.7
Overtime Scenarios					
OT 1	$139.3	$144.8	$238.8	$184.2	$180.7
OT 2	$69.7	$72.4	$119.4	$92.1	$90.4
OT 3	$0.0	$0.0	$0.0	$0.0	$0.0
Total Costs and Transfers by Scenario					
Reg Fam + MW + Travel + OT 1	*$192.1*	*$176.2*	*$289*	*$226*	*$222.2*
Reg Fam +MW + Travel + OT 2	*$122.4*	*$103.8*	*$169.6*	*$133.9*	*$131.9*
Reg Fam + MW + Travel + OT 3	*$52.7*	*$31.4*	*$50.2*	*$41.8*	*$41.5*
Deadweight Loss					
Reg Fam + MW + Travel + OT 1	$0.103	$0.080	$0.132	$0.105	$0.103
Reg Fam + MW + Travel + OT 2	$0.042	$0.027	$0.044	$0.036	$0.036
Reg Fam + MW + Travel + OT 3	$0.008	$0.002	$0.004	$0.003	$0.003
Disemployment (number of workers)					
Reg Fam + MW + Travel + OT 1	793	739	1,169	938[c]	
Reg Fam + MW + Travel + OT 2	505	435	686	544[c]	
Reg Fam + MW + Travel + OT 3	218	132	203	172[c]	

[a] These costs are a range where the first number represents the estimate for Year 2; the second estimate for Year 10.
[b] 2010 statistics on PCA and HHA wages indicate that few workers, if any, are currently paid below minimum wage (i.e. in no state is the 10th percentile wage below $7.25 per hour). See the BLS Occupational Employment Statistics, 2010 state estimates, at URL: http://stats.bls.gov/oes/
[c] Simple average over 10 years.
Columns may not sum to totals due to rounding.

State Law Requirements

In evaluating the economic impact of the proposed rule, it is important to consider the current wage requirements for home health care workers. There are numerous state laws pertaining to home health care workers. The State Medicaid Manual requires states to develop qualifications or requirements (such as background checks, training, age, supervision, health, literacy, or education, or other requirements) for Medicaid-financed personal care attendants. These state programs can each have multiple delivery models, with care being agency-directed or consumer-directed with care given by agencies or

independent providers. These delivery models are not necessarily mutually exclusive. In general, for the purposes of this analysis, we refer to independent providers as workers providing services through informal arrangements, and therefore they are not counted in the statistics on home health care providers used as the basis for this analysis.

A 2006 report by the HHS Office of the Inspector General (OIG) found that states have established multiple sets of worker requirements that often vary among the programs within a state and among the delivery models within programs, resulting in 301 sets of requirements nationwide.[9] Four of the consumer-directed programs in the OIG review had no attendant requirements.

Furthermore, states define these requirements differently, and specify different combinations of requirements in different programs. The most common requirements, and some characterization of how these might be defined by different programs, include:

- Background Checks. May include the following: criminal background checks; checks of abuse or neglect registries; and checks of Federal or State exclusion lists for previous fraudulent or abusive activities.
- Training. May include the following: first aid or cardiopulmonary resuscitation (CPR); basic health knowledge (e.g., food and nutrition, blood-borne pathogens, hygiene, universal precautions); assistance with daily living activities (e.g., patient transfer techniques, proper patient bathing and showering techniques, and grooming); program orientation (e.g., beneficiary rights and responsibilities, safety, behavioral issues, patient confidentiality); training specific to an individual beneficiary's needs; or other training.
- Supervision. Might be performed by registered or licensed practical nurses (RN or LPN); home health or personal care service agency staff; case managers; other qualified staff or individuals; or the beneficiary.
- Minimum Age. Most commonly set at 18-years-old, but in some states might be 14-years-old, 19-years-old, or of "legal working age."

[9] U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG). States' Requirements for Medicaid-Funded Personal Care Service Attendants, available at http://oig.hhs.gov/oei/reports/oei-07-05-00250.pdf. (2006).

- Health. May include the following: test negative for tuberculosis; be able to perform the services in the plan of care; meet an established minimum level of physical ability (e.g., able to lift a certain weight or stand for a certain time); be free of communicable disease; pass a physical examination; or drug test.

- Education/Literacy. Minimum requirements might include: an ability to read and write adequately to follow instructions or to keep records; a General Education Diploma (GED) or high school diploma; completed a certain grade; be a Certified Nursing Assistant (CNA) or a home health aide; have a Homemaker/Personal Care Service Provider certification issued by the state; be able to communicate with the beneficiary and/or supervisory staff; pass a competency test or have previous experience; have the skills, knowledge, and abilities necessary to perform the services needed; be able to meet the needs of the beneficiary; or be mature and sympathetic.

- Other. Might be required to: have a Social Security number; have an identification card; be a U.S. citizen; or meet state motor vehicle requirements if providing transportation.

The number of states that included each requirement in at least one program and the number of state program sets that include each requirement are summarized in Table 1-1.

Table 1-1. Six Most Common Attendant Requirements

Requirement	Number of States that Utilized Requirement in at Least One Program	Number of Sets Containing Requirement (of 301 sets)
Background Checks	50	245
Training	46	227
Age	42	219
Supervision	43	198
Health	39	162
Education/Literacy	31	125

Source: DHSS OIG, 2006. p. 9

States' laws also vary in whether they extend minimum wage and overtime provisions to home health care workers. In many states companions or home health care workers are not explicitly named in the regulations, but often fall under those regulations that apply to domestic service employees.

- 16 states extend both minimum wage and overtime coverage to most home health care workers who would otherwise be excluded under the current regulations: California, Colorado, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, Pennsylvania, Washington, and Wisconsin. However, in some states certain types of these workers remain exempt, such as those employed directly by households or by non-profit organizations. Additionally, New York's overtime law provides that workers who are exempt from the FLSA and employed by a third-party agency need only be paid time and one-half the minimum wage (as opposed to time and one-half of the worker's regular wage). Minnesota's overtime provision applies only after 48 hours of work.

- Five states (Arizona, Nebraska, North Dakota, Ohio, and South Dakota) and the District of Columbia extend minimum wage, but not overtime coverage to home care workers. There are again some exemptions for those workers employed directly by households or who live in the household.

- 29 states do not include home health care workers in their minimum wage and overtime provisions: Alabama, Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, and Wyoming.[10]

[10] National Employment Law Project (NELP). 2011. Fair Pay for Home Care Workers, available at http://www.nelp.org/page/-/Justice/2011/FairPayforHomeCareWorkers.pdf?nocdn=1.

Of the 22 jurisdictions that extend minimum wage to at least some home health care workers, 12 have a state minimum wage that is higher than the current federal minimum wage of $7.25 an hour.[11] These state laws are summarized in Table 1-2.

[11] U.S Department of Labor (DOL). 2011. Minimum Wage, available at http://www.dol.gov/dol/topic/wages/minimumwage.htm.

Table 1-2. State Minimum Wage and Overtime Coverage of Non-Publicly Employed Companions

State	State Minimum Wage [a]	MW	OT	Neither	Analysis and Citations [b]
AL	-			x	-
AK	$7.75			x	-
AZ	$7.35	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. No state overtime law. See Ariz. Rev. Stat. Ann. §§ 23□362, 23□363; see also Office of the Attorney General of the State of Arizona, Opinion No. I07□002 (Feb. 7, 2007).
AR	$6.25			x	-
CA	$8.00	x			All companions as defined in the FLSA are entitled to minimum wage. California's overtime rules create in terms of overtime four categories of workers who provide home care. (1) Those who are employed by non-profits and do no additional work beyond feeding, dressing, and supervising the person do not receive overtime. (2) Those who are employed by non-profits but do additional work beyond feeding, dressing, and supervising do receive overtime. (3) All for-profit workers receive overtime regardless of their job description. (4) County-employed home care worker, of whom there are approximately 367,000, receive up to $11.50 an hour straight time per their union contracts and may also receive overtime under those contracts. Industrial Welfare Commission Order No. 5-2001, "Judge Orders State to Halt Wage Cut for California Home Care Workers, http://www.seiu.org/2009/06/judge-orders-state-to-halt-wage-cut-for-california-home-care-workers.php (last visited Jun. 28, 2011); PHI, 2010a. p. 14.

Table 1-2. State Minimum Wage and Overtime Coverage of Non-Publicly Employed Companions

State	State Minimum Wage [a]	MW	OT	Neither	Analysis and Citations [b]
CO	$7.36	x	x		Minimum wage and overtime coverage for third-party-employed home care workers who do work beyond Colorado's definition of "companion." Colorado's definition of "companion" is much narrower than the FLSA definition. Companions may not help to bathe and dress the person, do any amount of housekeeping,or remind the person to take medication. People who do those tasks are more than just "companions" they are "personal care" attendants. Personal care attendants are entitled to minimum wage and overtime. However, PCAs employed directly by private households are exempt from minimum wage and overtime. Colorado Minimum Wage Order No. 26 § 5; 7 Colo. Code Regs. § 1103-1:5.
CT	$8.25			x	-
DE	$7.25			x	-
DC	$8.25	x			Minimum wage for companions as defined in the FLSA. D.C. Mun. Regs. tit. 7, § 902.1, 902.3, 902.4 (West 2011).
FL	$7.25			x	-
GA	$5.15			x	-
HI	$7.25	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for those employed directly by private households. Haw. Rev. Stat. § 387-1.
ID	$7.25			x	-
IL	$8.25	x	x		Minimum wage and overtime coverage for any person whose primary duty is to be a companion for individual(s) who are aged or infirm or workers whose primary duty is to perform health care services in or about a private home. There may be an exemption for those employed solely by private households as a result of a general exemption for employers with fewer than four employees. 820 Ill.Comp. Stat. § 105/3(d); Ill. Adm. Code § 210.110.
IN	$7.25			x	-

Table 1-2. State Minimum Wage and Overtime Coverage of Non-Publicly Employed Companions

State	State Minimum Wage [a]	MW	OT	Neither	Analysis and Citations [b]
IA	$7.25			x	-
KS	$7.25			x	-
KY	$7.25			x	-
LA	-			x	-
ME	$7.50	x	x		Minimum wage and overtime coverage for all companions as defined in the FLSA. No relevant exemptions. Me. Rev. Stat. Ann. tit. 26, §§ 663, 664.
MD	$7.25	x	x		Minimum wage coverage for all companions as defined in the FLSA. Overtime coverage for most home care workers but exemption for workers employed by non□profit agencies that provide "temporary at-home care services". Md. Code Ann., Lab. & Empl. § 3□415.
MA	$8.00	x	x		Minimum wage and overtime coverage for all companions as defined in the FLSA. No relevant exemptions. Mass. Gen. Laws Ch. 151, § 1.
MI	$7.40	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for live□in workers. Mich. Comp. Laws § 408.394(2)(a). Exemption for workers employed solely by private household as a result of exemption for employer with fewer than two employees. Mich. Comp. Laws § 408.382(c) .
MN	$6.15 or $5.25 for employers grossing under $625,000 per year	x	x		Minimum wage and overtime coverage after 48 hours for all companions as defined in the FLSA, but nighttime hours where companion is available to provide services but does not actually do so need not be compensated. Minn. Stat. § 177.23(11).
MS	-			x	-
MO	$7.25			x	-

Table 1-2. State Minimum Wage and Overtime Coverage of Non-Publicly Employed Companions

State	State Minimum Wage [a]	MW	OT	Neither	Analysis and Citations [b]
MT	$7.35	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for those employed directly by private households. Mont. Code. Ann. § 39□3□406(p).
NE	$7.25	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. No state overtime law. De facto exemption for most households as a result of general exemption for employers with fewer than four employees. Neb. Rev. Stat. §§48□1202, 48□1203.
NV	$8.25	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for live□in workers. Also, business enterprises with less than $250,000 annually in gross sales volume need not pay overtime. Nev. Rev. Stat. § 608.250(2)(b).
NH	$7.25			x	-
NJ	$7.25	x	x		Minimum wage and overtime coverage for all companions as defined in the FLSA. No relevant exemptions. N.J. Stat. Ann.§ 34:11□56a et seq..
NM	$7.50			x	-
NY	$7.25	x	x		Minimum wage coverage for all companions as defined in the FLSA. N.Y. Labor Law § 651 (5). There is overtime coverage for all companions but those employed by third party agencies receive overtime at a reduced rate of 150% of the minimum wage (rather than the usual 150% of their regular rate of pay). N.Y. Labor Law§§ 2(16), 170; N.Y. Comp. Codes R. & Regs. tit. 12, § 142□2.2. Overtime coverage for live□in workers after 44 hours/week (rather than the usual 40 hours) at the same rates detailed above. Id.
NC	$7.25			x	-

Table 1-2. State Minimum Wage and Overtime Coverage of Non-Publicly Employed Companions

State	State Minimum Wage [a]	MW	OT	Neither	Analysis and Citations [b]
ND	$7.25	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. However, companions who are certain first or send-degree relatives of the person receiving care do not receive minimum wage. Additionally, nighttime hours where companion is available to provide services but does not actually do so need not be compensated. N.D. Cent. Code § 34□06□03.1.
OH	$7.40			x	Minimum wage but not overtime coverage for companions as defined in the FLSA. Ohio Rev. Code Ann. § 4111.03 (A) § 4111.14 (West 2011). Additional overtime exemptions for live-in workers. Id. § 4111.03(D)(3)(d).
OK	$7.25			x	-
OR	$8.50			x	-
PA	$7.25	x	x		Minimum wage and overtime coverage for companions as defined in the FLSA, but exemption for those employed solely by private households. Pa. Stat. Ann. tit. 43, § 333.105(a)(2). *Bayada Nurses v. Commonwealth of Pennsylvania*, 8 A.3d 866 (Pa. 2010).
RI	$7.40			x	-
SC	-			x	-
SD	$7.25	x			Minimum wage but no overtime coverage for companions as defined in the FLSA. No state overtime law. S.D. Codified Laws§§ 60□11□3, 60□11□5.
TN	-			x	-
TX	$7.25			x	-
UT	$7.25			x	-
VT	$8.15			x	-
VA	$7.25			x	-
WA	$8.67	x	x		Washington minimum wage and overtime coverage for most companions as defined in the FLSA, but exemption for live□in workers. Wash. Rev. Code § 49.46.010(5)(j).
WV	$7.25			x	-

Table 1-2. State Minimum Wage and Overtime Coverage of Non-Publicly Employed Companions

State	State Minimum Wage [a]	MW	OT	Neither	Analysis and Citations [b]
WI	$7.25	x	x		Minimum wage and overtime coverage for most companions as defined in the FLSA, but overtime exemption for those employed directly by private households, Wis. Admin. Code § 274.015, and those employed by non□profit organizations. Wis. Admin. Code §§ 274.015, 274.01. Companions who spend less than 15 hours a week on general household work and reside in the home of the employer are also exempt from minimum wage. Wis. Admin. Code § 272.06(2).
WY	$5.15			x	-

Abbreviations: MW = Minimum Wage, OT = Overtime, FLSA = Fair Labor Standards Act
Sources: [a] DOL, 2011; [b]NELP, 2011.

Data Sources

The primary data services used by the Department to estimate the number of workers, establishments, and customers likely to be impacted by the proposed rule include:

- Bureau of Labor Statistics (BLS) 2009 Occupational Employment Survey, employment and wages by state for SOC codes 39-9021 (Personal Care Aides) and 31-1011 (Home Health Aides);
- BLS Quarterly Census of Employment and Wages, 2009 for NAICS 6216 and 62412;
- BLS National Employment Matrix, 2008;
- 2007 Statistics of U.S. Businesses, for NAICS 6216 and 62412; and
- 2007 Economic Census, by state for NAICS 6216 and 62412.

The key limitation of this set of data sources is that it results in an inconsistency between the Department's best estimate of agency-employed caregivers (from the 2009 BLS Occupational Employment Survey), and its best estimate of independent providers directly employed by families (from the 2008 BLS National Employment Matrix). The Occupational Employment Survey (OES) is employer based, and does not collect data from the self-employed. The National Employment Matrix (NEM) obtains estimates on the self-employed from the Current Population Survey. However, it is not possible to match the OES estimates by subtracting the estimated number of self-employed workers from the NEM. Because these two estimates cannot be completely reconciled, the Department uses each source as the best estimate for one segment of the labor market and acknowledges there is some inconsistency between the two.

Care Recipients and Demand for Services

Demand for home health care services is anticipated to continue to grow in the next few decades with the aging of the "baby boomer generation." According to PHI:

> Nearly one out of four U.S. households provides care to a relative or friend aged 50 or older and about 15 percent of adults care for a seriously

> ill or disabled family member. Over the next two decades the population over age 65 will grow to more than 70 million people [the U.S. population 65 years and older was estimated at 40 million in 2009[8]]. Additionally, with significant increases in life expectancy and medical advances that allow individuals with chronic conditions to live longer, the demand for caregiving is expected to grow exponentially. The growth in the demand for in-home services is further amplified by an increasing preference for receiving supports and services in the home as opposed to institutional settings. This emphasis has been supported by the increased availability of publicly funded in-home services under Medicaid and Medicare as an alternative to traditional and increasingly costly institutional care.[9]

While many recipients of home health care services are elderly, about two-fifths of those in need of these services are under 65 and include those with varying degrees of mental or developmental disabilities. This group of home health care recipients is also anticipated to grow rapidly as more individuals opt for home-based care over institutional settings.[10] It is estimated that the demand for home health care workers will grow to approximately 5.7 to 6.6 million workers in 2050, an increase in the current demand for workers of between 3.8 and 4.6 million (200 percent and 242 percent respectively).[11] The home health care industry has grown significantly over the past decade and is projected to continue growing rapidly; for example:

- The number of establishments in Home Health Care Services (HHCS) grew by 70 percent between 2001 and 2009; during that same period, the number of establishments in Services for the Elderly and Persons with Disabilities (SEPD) grew by 355 percent.[12]
- Between 2008 and 2018 the number of home health aides is projected to increase by 50 percent and the number of personal care aides by 46 percent.

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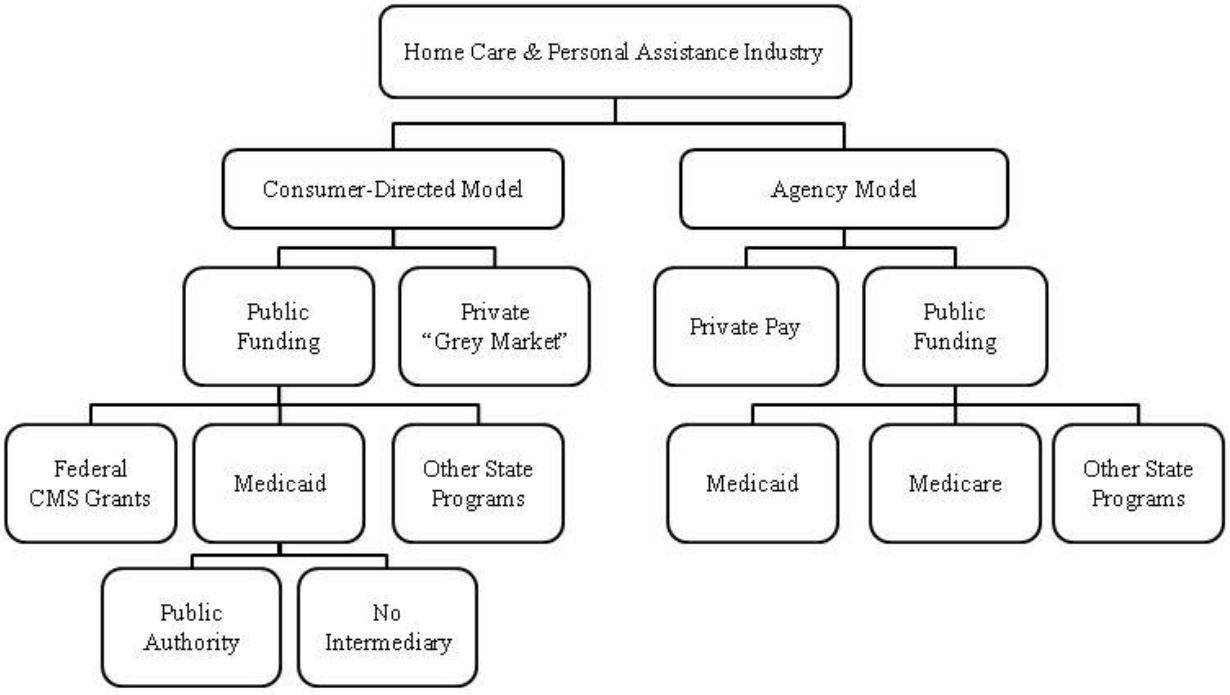
[8] 2011 Statistical Abstract, U.S. Census Bureau.
[9] National Alliance for Caregiving and the American Association of Retired Persons. 1997. Family caregiving in the U.S.: Findings from a national study. Available from http://www.caregiving.org.
[10] PHI, 2003. The Personal Assistance Services and Direct-Support Workforce: A Literature Review, available at http://www.directcareclearinghouse.org/download/CMS_Lit_Rev_FINAL_6.12.03.pdf.
[11] HHS, 2001. Pgs. 4, 5, and 7.
[12] U.S. Bureau of Labor Statistics (BLS). 2008. National Employment Matrix - Search by Occupation, available at http://data.bls.gov/oep/nioem?Action=empios&Type=Occupation.

Employers and Funding Sources

This section focuses on the employers of workers who are currently classified as companions and common sources of funding for the services they provide; the next section describes the workers and the work they do. Services in the home health care industry are provided through two general delivery models: agencies and consumer-directed (which often use independent providers and family caregivers).

Figure 2 provides a visual overview of the home care and personal assistance industry and the two primary models for service provision, which are discussed in more detail in the sections that follow.

Figure 2. Overview of the Home Health Care Industry and Funding Sources



Agency Model

Under the agency model a third-party provider of home care and personal assistance services (usually a home health care company) employs the home care workers and is responsible for ensuring that services authorized by a public program or contracted for by a private party are in fact delivered.[13] There are currently about 73,000 establishments providing these services. The services are paid for through public programs such as Medicaid, Medicare, and other state programs, and through private sources such as private health insurance or out-of-pocket payments. In 2009, public programs (Medicare, Medicaid, and other government spending) accounted for about 75 percent ($63.1 billion) of the $84.1 billion in annual revenue dispersed to these agencies.[14]

Agencies providing home care and personal assistance services are covered by two primary industries: Home Health Care Services (HHCS, NAICS 6216), and Services for Elderly and Persons with Disabilities (SEPD, NAICS 62412).[15] HHCS is dominated by for-profit agencies that are Medicare-certified and depends on public programs for three-quarters of its revenue.[16] SEPD is a rapidly growing industry that is dominated by small non-profit enterprises. Table 2-1 provides an overview of these two industries in terms of number of employees, establishments, payroll and wages, and estimated revenues.

Table 2-1. Summary of HHCS and SEPD, 2009

Industry	Employees [a]	Establish-ments	Total Wages ($ mil.)	Avg Weekly Wage	Est. Revenue ($ mil.)

[13] Seavey and Marquand, 2011, pg. 26. Available at: http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf

[14] Seavey and Marquand, 2011, pgs 22,23. Available at: http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf

[15] These two industries are the primary employers of workers currently classified as companions; however, based on data reported by BLS in the National Employment Matrix there are approximately 25 other industries that also employ these workers. Since these other industries employ so few of the workers under consideration here they will be minimally affected by this proposed rule.

[16] Seavey and Marquand, 2011, pgs 20-22. Available at: http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf

SEPD + HHCS	**1,714,000**	**73,200**	**$413,181**	**$464**	**$80,307**
SEPD	679,600	49,100	$133,247	$377	$28,645
HHCS	1,034,400	24,100	$279,934	$520	$51,662

[a] Employees include HHA, PCA, and other occupations
Sources: BLS QCEW 2009; BLS National Employment Matrix, 2008.

These two industries primarily employ workers as home health aides (HHA) and personal care aides (PCA) in addition to other occupations. However, not all of the HHA and PCA employed by these agencies work as companions under the companionship exemption; these agencies provide a variety of health-related services that may be delivered in private homes (and potentially companionship services) or in public or private facilities (and not defined as companionship services). Simply put, only a fraction of the 1.7 million employees listed in the table above are currently working as exempt companions who may see changes in their wages and/or work schedules as a result of the proposed rule.

Within these two industries there are three broad employer types: home health care companies, for-profit franchise chains, and private-duty home care companies. The latter two types are smaller, emerging types of employers that focus on the provision of non-medical care for clients. Home health care companies focus on providing medically-oriented home health care services and non-medical home care or personal assistance services. Many of these agencies are Medicare-certified; those that avoid obtaining certification do so because they do not provide the skilled nursing care required by Medicare. These companies also derive a significant portion of their revenue from the provision of medical devices to customers.[17]

Consumer-Directed Models

[17] PHI, 2010a. p.2.

Under the consumer-directed model, the consumer or his/her representative has more control than in the agency-directed model over the services received, and when, how, and by whom the services are provided. The approaches to delivering services under this model range from the more formal state-organized systems to informal arrangements coordinated through word-of-mouth between care recipients. In the public version of this model, the care is funded either by Medicaid, directly by states, or through programs or grants administered by the HHS Centers for Medicare & Medicaid Services (CMS).

Other recipients arrange for and pay for care privately through informal negotiations with individual service providers. In this model, the customer may act as the sole or a joint employer and has varying degrees of responsibility for interviewing, hiring, training, managing, and firing the provider. Due to the sometimes informal nature of the consumer-directed employment arrangements, there are no data on the total number of customers under this model, and there is limited information on the total number of providers. BLS National Employment Matrix data show that 127,000 Personal Care Aides (about 16 percent) are employed in private households and 61,500 (about 8 percent) are self-employed, for a total of 188,500 workers (about 23 percent) that may provide services as independent contractors.[18] Fewer Home Health Aides are employed in this manner, with 1,700 (less than one percent) working for private households and 16,400 (about two percent) who are self-employed. Combining the data for Personal and Home Health Aides suggests that 206,600 of these workers (about twelve percent) may be either self-employed or employed in private households. The Department believes that these workers can reasonably be described as independent providers that directly provide caregiver services to families, perhaps through informal arrangements.

[18] BLS, 2008.

However, consumer-directed employment is sometimes referred to as a "grey market;" that contains an element of "over-the-back-fence network of women [who are] usually untrained, unscreened, and unsupervised, but more affordable without an agency's fee, less constrained by regulations and hired through personal recommendation."[19] The term "grey market" is sometimes used to suggest that at least some of these private arrangements are designed to avoid applicable labor laws; the extent to which care recipients use private arrangements for this purpose is unclear; there is very little information available about this segment of the market for home health services. It is also possible, and likely, that care providers who are employed by an agency or who provide services through a state registry also occasionally provide services through informal arrangements. The Department's best estimate of consumer-directed employment is summarized in the previous paragraph, and we are unable to estimate the extent to which the group of providers described above participates in the informal market. We are also unable to characterize the extent to which other providers not included in this estimate participate in the "grey market."

There is no consolidated source of data on state consumer-directed programs; however, PHI offers an overview of what programs are offered: seven states have no publicly-funded consumer-directed program, 38 states offer options under one or more Medicaid Waivers, seven states offer options under Medicaid Home Health programs, and 12 states offer consumer/participant-directed options under Medicaid Personal Care Option.[20]

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[19] Gross, J., *New Options (and Risks) in Home Care for Elderly*. New York Times available at http://nytimes.com/2007/03/01/us/01aides.html. March 1, 2007).

[20] Seavey and Marquand, 2011, pg 28. Available at: http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf

Of those states that do offer a consumer-directed program, some have implemented a "public authority" model. In this model, a public authority or some other governmental or quasi-governmental entity plays a role in setting compensation and other employment terms for the service provider, who is compensated through public funds, acts as the "employer-of-record," and may provide training, and create and maintain registries of providers.[21] Service providers in this system have the option to select representatives for collective bargaining with the state. Six states (California, Massachusetts, Michigan, Oregon, Washington, and Wisconsin) have fully implemented a public authority, and Missouri is in the process of doing so. Several states have implemented a consumer-directed program without creating a public authority, they include: Illinois, Iowa, Maryland, and Ohio.

California's policies are of particular note because it has one of the largest home care caseloads. This is due to a combination of demographic factors and a robust social movement of the disabled community that created Centers for Independent Living in the 1970s.[22] California's In-Home Supportive Services (IHSS) program was created in 1973. IHSS is the largest personal care program in the nation and is funded through a combination of state, county, and federal Medicaid funds.[23] A 2000 study of independent home care workers found that IHSS employed more than 200,000 independent personal care workers through IHSS, 72,000 in Los Angeles County alone.

IHSS initially allowed counties to organize the service in different ways, and each had a different approach to employing the worker. Under the individual provider model, the

[21] PHI, 2010a. p. 14.
[22] Boris, E. & Klein, J. 2006. Organizing home care: Low-waged workers in the welfare state, available at http://escholarship.org/uc/item/21x6q48g;jsessionid=197876DF1E12B3D17476457ED5FE5E24#page-6.
[23] PHI, 2010b. California's Direct-Care Workforce. Available at http://www.directcareclearinghouse.org/download/CA%20Fact%20Sheet-%2011-04-10.pdf.

consumer hired the worker and the worker was considered an independent contractor, with the state paying for the service and social workers allocating hours. Under the county model, the worker was a government employee. Under the contract model, the county contracted with an agency which became the employer.[24] Ambiguity about who was really employing IHSS workers continued in the following decades. In 1985, California's attorney general determined that IHSS attendants came under state workers' compensation and other labor laws, and were county employees for purposes of collective bargaining. However in Service Employees International Union, Local 434 v. County of Los Angeles, the court found IHSS workers to be independent contractors because the counties did not control their activities directly.[25] In 1992, California began to establish county-based public authorities. Under the public authority model, workers are no longer self-employed, and the employer responsibilities are split between the public authority (which serves as the employer in collective bargaining with the union) and the consumer (who is responsible for the selecting, hiring, and supervising of workers).[26] Today there are approximately 367,000 home care workers employed by the California public authority.[27]

In an effort to connect participants in consumer-directed programs with care providers, some states and public authorities have created matching registries; these systems provide some insight into how consumers identify care providers to meet their needs. Depending on the registry, consumers can either search the worker database online, or speak to trained staff who conduct the search and report the results to the

[24] Boris & Klein, 2006.
[25] Boris & Klein, 2006.
[26] PHI, 2011b. California Direct Care Workforce Initiatives,. available at http://www.directcareclearinghouse.org/s_state_det1.jsp?res_id=5&action=null.
[27] PHI, 2010a.

consumer. Some registries may also offer worker screening and orientation, access to consumer and worker training, and recruitment and outreach to potential workers.[28] Others stipulate that providers in the database have not been pre-screened in any way and such responsibilities lie with the consumer. The PHI Matching Services Project[29] has identified 16 state-based matching services and six states with regional matching services. Of the 16 state-based matching services, five (California, Massachusetts, Michigan, Oregon, and Washington) operate under a public authority. Wisconsin's registry, which also operates under a public authority, is currently regional but scheduled to become state-wide in 2011. These registries are listed in Table A-1 in APPENDIX A. PHI notes that these public matching registries are not to be confused with the registries that exist in all states to perform criminal background checks on potential care providers or verify nursing training.

The Department also located registries operated by not-for-profit organizations, such as the Meals on Wheels of Contra Costa County Home Care Registry,[30] where the registry recruits, screens, and checks the references of local care providers, but the care providers are self-employed and work as independent contractors. Various private sector entities that refer to themselves as registries[31, 32, 33, 34], however, appear to be operating under an agency or quasi-agency model, with the care recipient paying the company a

[28] PHI, 2011a. The PHI Matching Services Project, available at http://phinational.org/policy/the-phi-matching-services-project/.
[29] PHI, 2011a.
[30] Meals on Wheels of Contra Costa County. 2011. Home Care Registry, available at http://www.mowsos.org/pages/page.php?pageid=48.
[31] Experienced Home Care Registry. 2011. About Us, available at http://www.experiencedhomecare.com/pgs/about_us.php.
[32] Angelic Nursing & Home Care Registry, Inc. 2011. Home Care Services for Seniors in Tolland and Hartford Counties in Connecticut, available at http://angelicregistry.com/.
[33] Golden Care Co. Inc. 2011. Billing Policy, available at http://www.goldencareco.com/billing.asp.
[34] American HealthCare Capital. 2011. $1.5 Million Oregon Private Pay Homecare Registry for Sale, available at http://www.americanhealthcarecapital.com/Listings/Current/orpd1a.html.

weekly or bi-weekly registry fee in addition to paying the caregiver, or with the company receiving some portion of the caregiver's hourly rate.

When consumers are allowed to hire any worker they choose, many choose friends or family members. For instance, the Cash and Counseling demonstration program provides a monthly allowance to Medicaid beneficiaries that beneficiaries can use to hire their choice of worker. In this program, 58 percent of directly hired workers in Florida, 71 percent in New Jersey, and 78 percent in Arkansas were related to the consumer, and about 80 percent of those directly hired workers had provided unpaid care to the consumer before the demonstration began.

Since the passage of the National Family Caregiver Support Program enacted under the Older Americans Act Amendments of 2000, Medicaid waivers and state-funded programs have provided the bulk of public financing to support family caregiving.[35] A survey of state consumer direction and family caregiving programs found that:

Over one-half (86 out of 150, or 57 percent) of the programs in 44 states and the District of Columbia say family members can be paid to provide care. Viewed another way, the vast majority of programs that offer some component of consumer direction, allow payment to relatives to provide care (86 out of 106 programs, or 81 percent). Only six states (Alaska, Delaware, Mississippi, Nevada, Pennsylvania, and Tennessee) did not allow payments to family members in any of their programs at the time of the study.[36]

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[35] Feinberg, L. & Newman, S. 2005. Consumer Direction and Family Caregiving: Results from a National Survey, State Policy in Practice, available at http://www.hcbs.org/files/79/3926/ConsumerDirection&FamilyCaregivingNWEB.pdf
Feinberg, L. et al. 2004. The State of the States in Family Caregiver Support: A 50-State Study. San Francisco, CA: Family Caregiver Alliance; available at http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1276.

[36] Feinberg & Newman, 2005. p. 8.

Of the 86 programs that allow relatives to be paid providers, 73 percent allow family members to provide personal care, 70 percent allow family members to provide respite care, 20 percent allow family members to act as homemakers or do chores, and 6 percent allowed family members to provide any service needed.[37] Some programs place restrictions on what type of family members are allowed to be paid providers as well. Among these 86 programs, 61 percent do not permit spouses to be paid providers, while others do not permit parents/guardians (37 percent), primary caregivers (18 percent), legal guardians (8 percent), children 18 and under (6 percent), or other relatives (4 percent).[38] These programs and their stipulations about payment to family caregivers are summarized in Table B-1 in APPENDIX B.

Funding Sources

There are a variety of different funding sources for provision of home health services. Table 2-3 provides an overview of these funding sources, care recipient eligibility requirements, and types of home health services covered. Public funding sources such as Medicare and Medicaid provide a majority of the reimbursement for services. In 2008, Medicare and Medicaid accounted for nearly 75 percent of home health care services revenue, followed by 15 percent from private insurance coverage, five percent from patients paying out-of-pocket, and the remaining five percent contributed by a mix of other government programs.[39]

[37] Feinberg & Newman, 2005. p. 8.
[38] Feinberg & Newman, 2005. p. 9.
[39] PHI, 2010a, p.6.

In 2009, HHS outlays for Medicare programs totaled $424 billion, and outlays in support of Medicaid totaled $251 billion.[40] Under Medicare, an estimated $18.3 billion went to home health programs.[41] In 2006, Medicaid programs accounted for approximately $38.1 billion (about $40 billion inflated to 2009 dollars) through Medicaid Home Health ($4.6 billion), State-Plan Personal Care Services benefit ($8.5 billion), and Medicaid Home and Community-based Services (HCBS) benefits ($25 billion).[42] Thus, payments for home health care programs composed approximately 4 percent of Medicare spending, and about 15 percent of Medicaid spending.

Both Medicaid and Medicare pay the service provider directly. The Medicare program uses a prospective payment system (PPS) to reimburse home health agencies a pre-determined base payment for an episode of care; this base payment is adjusted for the condition and needs of the beneficiary as well as geographic variation in wages.[43] Under Medicaid, the state agency implementing the program pays the service provider directly except under certain consumer-directed programs.

The Medicare and Medicaid programs also work together to provide services for a group of care recipients referred to as "dual eligibles," that is, care recipients that are eligible for both Medicare and Medicaid coverage. Studies have found that individuals covered by both Medicare and Medicaid are among the most expensive groups to cover and are more likely to use more Medicare-covered home health services than Medicare

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[40] U.S. Department of Health & Human Services (HHS). 2011. FY 2011 Budget, available at http://dhhs.gov/asfr/ob/docbudget/2011budgetinbrief.pdf. p. 13.
[41] Medpac. 2010. A Data Book: Healthcare Spending and the Medicare Program, p. 139, available at http://www.medpac.gov/documents/jun10databookentirereport.pdf
[42] PHI, 2010a, p. 18. Note, not all of the HCBS goes to personal care services; a more detailed breakdown of this spending is not available. For additional data, see Kaiser Family Foundation, State Health Facts: http://statehealthfacts.org/comparetable.jsp?ind=242&cat=4.
[43] For additional detail see Center for Medicare & Medicaid Services (CMS). 2011a. Home Health PPS, available at http://www.cms.gov/HomeHealthPPS/.

home health care patients not also covered by Medicaid. Also, states with low Medicaid spending appear to shift costs to the Medicare home health program spending.[44] Most of the public matching registries listed in Appendix A are funded by the state, with a few receiving federal dollars through reimbursement for Medicaid administrative costs or receiving initial funding through federal Medicaid Systems Transformation grants.[45]

Table 2-2. Summary of Home Health Care Service Payers and Service Coverage

Payer	Description	Eligibility	Home Health Service Coverage
Public			
Medicare	Federal government program to provide health insurance coverage, including home health care, to eligible individuals who are disabled or over age 65. The program pays a certified home health agency for a 60 day episode of care during which the agency provides services to the beneficiary based on the physician approved plan of care.	Individual is under the care of a doctor and receiving services under plan of care; has a certified need for intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational therapy; and must be homebound. HHA providing services is Medicare-certified; services needed are part-time or intermittent, and are required <7 days per week or <8 hours per day over 21 day period.	Intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational therapy. Does not cover 24hr/day care at home; meals delivered to home; homemaker services when it is only service needed or when not related to plan of care; personal care given by home health aides when it is only care needed.
Medicaid	A joint federal-state medical assistance program administered by each state to provide coverage for low income individuals. The program pays home health agencies and certified independent providers.	Eligibility and benefits vary by state. In general, states must cover individuals who receive federally assisted income maintenance payments such as Social Security, individuals who are eligible for Temporary Assistance for Needy Families and to other individuals defined as "categorically needy."	Coverage of home health services must include part-time nursing, home care aide services, medical supplies and equipment. Optional state coverage may include audiology; physical, occupational, and speech therapies; and medical social services. Coverage is provided under: Medicaid Home

[44] Center for Medicare & Medicaid Services (CMS). 2011b. Home Health Study Report: Literature Review, available at http://www.cms.gov/HomeHealthPPS/Downloads/HHPPS_LiteratureReview.pdf. p.16.
[45] Seavey & Marquard, 2011.

Table 2-2. Summary of Home Health Care Service Payers and Service Coverage

Payer	Description	Eligibility	Home Health Service Coverage
			Health, State Plan Personal Care Services benefit, and Home and Community-Based state plan services and waivers.
Older Americans Act	Provides federal funding for state and local social service programs that provide services so that frail, disabled, older individuals may remain independent in their communities.	Must be 60 yrs of age or older.	Home care aides, personal care, chore, escort, meal delivery, and shopping services.
Veterans Administration	Home health care services provided through the VA's network of hospital-based home care units.	Veterans who are at least 50% disabled due to service-related conditions.	Home health care. Does not include nonmedical services provided by HCAs.
Social Services Block Grant	Federal block grants to states for state-identified service needs.	Varies by state.	Often includes program providing home care aide, homemaker, or chore worker services.
Community organizations	Some community organizations provide funds for home health and supportive care.	Varies by program.	Covers all or a portion of needed services. Vary by program.
Private			
Commercial Health Insurance Companies	Many policies cover home care services for acute, and less often, long-term needs.	Varies by policy.	Varies by insurance policy.
Medigap Insurance	Covers some personal care services when a Medicare beneficiary is receiving covered home health services.	Varies by policy.	Focused on short-term personal care services in support of Medicare covered home health care skilled nursing services.
Self-Pay	The individual receiving the services pays "out of pocket."	Individuals who are not eligible for covered services under third-party public or private payers.	Services that do not meet the eligibility criteria of other payers.

Sources: National Association for Home Care. 1996. Who Pays for Home Care Services? Available at URL: www.nahc.org/consumer/wpfhcs.html; Centers for Medicare and Medicaid Services (CMS). Medicare and Home Health Care. Available at URL: http://www.medicare.gov/publications/pubs/pdf/10969.pdf

Home Health Care Workers

This section provides an estimate of the total number of home health care workers who may be impacted by the proposed rule as well as the characteristics of these workers, the services they provide, and the wages they receive for their work.

Number of Affected Workers

The workers who will be directly affected by the change to the companionship exemption are concentrated in two occupations: Home Health Aides (SOC 31-1011) and Personal Care Aides (39-9021). These workers are concentrated in two industries: Home Health Care Services (NAICS 6216) and Services for the Elderly and Disabled Persons (NAICS 62412).

These workers are predominantly women in their mid-forties, minorities, with a high school diploma or less education but this varies highly by region. A similar percentage of PCAs are Black and Hispanic (20% and 19%, respectively), but a much higher percentage of HHAs are Black (35%) than Hispanic (8%). One in four (25%) PCAs are foreign-born, with higher percentages (over 50%) in certain regions of the country, e.g., California and New York. California also has a high percentage of caregivers who are paid family members.[46]

Home health care workers are called by a variety of titles, including: home health aides, home care aides, personal care aides, personal assistants, home attendants, homemakers, companions, personal care staff, resident care aides, and direct support professionals. They are tracked by the following occupational titles. [47]

Personal Care Aide (SOC 39-9021): "Assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility.

[46] PHI, 2010a. p. 9.
[47] U.S. Bureau of Labor Statistics (BLS). 2011. Standard Occupational Classification, available at http://www.bls.gov/soc/home.htm.

Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities."

Home Health Aide (SOC 31-1011): "Provide routine individualized healthcare such as changing bandages and dressing wounds, and applying topical medications to the elderly, convalescents, or persons with disabilities at the patient's home or in a care facility. Monitor or report changes in health status. May also provide personal care such as bathing, dressing, and grooming of patient."

Note that the companionship services of fellowship and protection are not included in either the definition of personal care aide or home health aide. Companionship services as defined in this NPRM are separate from the services provided by home health care workers as defined officially above and outlined in detail below.

The Department uses BLS' employer-based OES estimate of the number of workers in the PCA and HHA occupational categories as its best estimate of the number of caregivers employed by agencies that might be affected by the proposed rule. There were approximately 1.59 million caregivers employed by agencies in 2009, composed of

- 631,000 PCAs, and
- 955,000 HHAs.[48]

These data do not include workers providing these services as independent providers who may be affected by the proposed rule. As described above, the Department determined from the NEM that an estimated additional

[48] 2009 BLS Occupational Employment Survey, employment and wages for SOC codes 39-9021 and 31-1011.

- 188,500 PCAs, and
- 18,100 HHAs[49]

can be considered independent providers directly employed by families. Thus, we estimate

- 819,500 PCAs, and
- 973,100 HHAs,

for a total of 1.79 million caregivers, might be affected by the proposed rule.

However, not all 1.79 million of these PCAs and HHAs are employed as FLSA-exempt companions. Many of these workers are employed at agencies that provide a variety of health-related services that may or may not be provided in the home; HHA and PCA employed in facilities, such as nursing homes and hospitals, are not classified as providing companionship services. Furthermore, many of these workers who are classified as companions are employed in states which currently provide minimum wage and overtime coverage. Only a subset of the 1.79 million workers, those who provide services in the home and are not eligible for minimum wage or overtime pay under state law, will be directly impacted by the proposed rule. The Department will define the number of workers directly affected by both the minimum wage and overtime pay provisions of the proposed rule.

While many agency-employed caregivers might work in various facilities that make them ineligible for the FLSA companionship exemption, there is little information available concerning independent providers. The Department assumes that all PCAs and HHAs classified in the NEM as self-employed or employed by households are

[49] BLS, 2008.

independent providers directly employed by the family, and are thus by assumption currently exempt from the FLSA.

Tasks, Wages, Hours

Traditionally, companionship tasks have been defined to include fellowship, care, protection, and a limited amount of assistance with general household tasks.[50]

- Fellowship: Defined in the proposed regulation as meaning "to engage the person in social, physical, and mental activities, including conversation, reading, games, crafts, walks, errands, appointments, and social events."[51] Fellowship services are generally not covered by public programs.
- Protection: Defined in the proposal as "being present with the person in their home or to accompany the person when outside of the home to monitor the person's safety and well-being."[52] Some states reimburse specific types of participants (i.e., those living with mental disabilities) for protection services.
- Social support: Services that enable the consumer to take an active part in his or her family and community, includes accompanying the consumer to regular social activities and ensuring that the consumer's cognitive state does not deteriorate due to social isolation.

The spectrum of tasks performed by modern workers classified as companions has expanded beyond traditional companionship to include: activities of daily living (ADLs), instrumental activities of daily living (IADLs), and paramedical ("medicalized") tasks.

[50] Federal Register, 2001. p.5481.
[51] Proposed § 552.6.
[52] Proposed § 552.6.

- ADLs: Assistance with the following activities: personal hygiene, dressing and changing clothes, transferring, toileting, eating and drinking, maintaining continence, and ambulation.
- IADLs: Includes tasks such as light housework, preparation of meals, assistance with physical taking of medications, shopping for groceries or clothes, using the telephone, escorting, assistance with the management of money, and other tasks that allow the consumer to live independently in the community.
- Paramedical tasks: May include tasks such as changing of aseptic dressings, administration of non-injectible medications (e.g., blood pressure medication in tablet form);[53] and ostomy, catheter and bowel hygiene.

While PCAs and HHAs overlap to some extent in the type of services they provide – both generally provide assistance with ADLs and IADLs – it is primarily HHAs who are employed by Medicare-certified agencies who may be asked to perform paramedical tasks. Those workers are required by Medicare to be trained and certified to perform these types of tasks.

Generally speaking, a home health aide or agency is authorized to provide a specific number of hours of service to care recipients depending on their needs. Agencies work to schedule home health aides to cover the number of hours needed for the portfolio of cases they have, often taking into account continuity of service to each recipient, total number of hours each aide is scheduled per week, frequency of weekend services needed, and the distance between the aide's home residence and the care recipient's. In the home care

[53] Administration of an injectible medication is a medical task generally performed by workers with additional training in medical tasks, such as Certified Nurse Assistants (CNAs).

industry, agencies typically strive to provide services seven days a week and 24 hours a day.

The greatest scheduling challenges to the agencies come from 12-hour and 24-hour (or sleep-in) cases; these cases are also of particular concern with respect to overtime. A 12-hour case is a care recipient who requires services to be provided by a home health aide for a 12-hour block of time; a 24-hour case is a care recipient who requires a home health aide to be present to provide services around the clock. The key scheduling concerns that agencies contend exist with these cases are that:

- Because workers are scheduled to work in lengthy shifts (up to 12 hours), it is difficult to redistribute overtime hours to workers with fewer hours;
- Aides are paid an hourly rate, plus an hourly overtime premium where applicable; however, agencies are often reimbursed for these cases on a flat rate that does not account for overtime premiums or other costs;
- Sleep-in cases usually include an eight-hour period to allow the worker to sleep while on site; however, the aide is not necessarily off-duty because s/he would be expected to assist the client if an urgent need arose. If the agency is required to count sleep hours toward the total number of hours worked per week then it may become costly to provide 24-hour care.

Some agencies take a proactive approach to scheduling these cases in order to manage the total number of hours on duty required from each worker. For example, an agency may split a 12-hour case between two aides by having one aide provide services Sunday through half of the Wednesday shift when the second aide would take over and work

through Saturday.[54] This reduces the total number of hours each aide must work, limits the work to one weekend day, and avoids overwhelming the care recipient with too many different care providers. A similar approach may be applied to cases that require 24-hour care.[55]

The workers themselves report working an average of 31 to 35 hours per week and available data suggest that very few work overtime.[56] Based on an analysis of the 2007 National Home Health Aide Survey and the 2009 Annual Social and Economic Supplement of the Current Population Survey, PHI reports that 92 percent of HHAs and 85 percent of PCAs work less than 40 hours per week for an average of 31 hours and 35 hours per week, respectively. By extension, only eight percent of HHAs and 15 percent of PCAs reported working greater than 40 hours per week.

However, this information may not fully capture the total number of hours worked by these individuals because some aides work for multiple employers, many aides work part-time, and some employers do not compensate workers for travel time between clients (because they are not reimbursed for this time). Furthermore, there is very limited information on hours worked by independent providers or those working as live-in, on-call, or night shift aides. The Department assumes that in general independent providers directly employed by families work similar hours as caregivers employed by agencies.

The wages for these workers vary widely by occupation and geographic location. Based on detailed wage data from the BLS Occupational Employment Statistics Survey,

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[54] Elsas, M. & Powell, A. 2011. Interview of Michael Elsas, President, and Adria Powell, Executive Vice President of Cooperative Health Care Associates by Calvin Franz and Lauren Jankovic of ERG. April, 2011.

[55] Some agencies have experimented with breaking a 24 hour case into two 12 hour cases that are staffed by four home care aides; this reduces total number of hours worked and eliminates the need for the 8 hour rest period but also increases the number of aides that the client must become comfortable with.

[56] Seavey and Marquand, 2011, pgs. 61-64. Available at: http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf; HHS, 2011. p.26.

the hourly wages of PCAs and HHAs range from about $6.79 to $20.61 (approximately 0.5% earn less than $6.79 and 0.5% earn more than $20.61) with the average wage being approximately $10.14.[57] As discussed above, wages for PCAs tend to be slightly lower on average than those for HHAs. The Department assumes that in general independent providers directly employed by families receive similar hourly wages as caregivers employed by agencies. In 70 percent of states (36 states), average hourly wages for PCAs were below 200 percent of the federal poverty level wage ($10.42) for individuals in one-person households working full-time. Current research suggests that these workers find it difficult to support their households on these wages; approximately 44 percent of PCAs have to rely on public benefits and fewer than 20 percent report having health insurance. [58]

Costs and Transfers

This section describes the costs and transfers associated with the proposed rule and the Department's approach to estimating their magnitude. The primary costs of this rule are expected to be regulatory familiarization. The Department estimates the first-year cost of the rule will total $9.9 million. In following years, regulatory familiarization costs are projected to increase from $3.5 million in year 2, to $4.4 million in year 10 as new firms enter the market and new families hire home health care workers.

Transfers result from the wage increases to comply with minimum wage and overtime pay requirements. Total estimated transfers depend in part on the response of employers to the regulatory changes; in other words, will employers respond by paying overtime to current workers, changing scheduling practices to avoid paying overtime, hiring

[57] BLS, 2009.
[58] PHI, 2010a., p. 30, 32.

additional workers, or some combination of these approaches. Based on the methods described below, the Department estimates that first-year transfers from the rule will range from $42.8 to $182.1 million. In years 2 through 10, the lower end of the range is projected to increase from $27.8 million to $45.8 million while the upper end of the range is projected to increase from $172.6 million to $284.6 million.

Total costs and transfers from the rule will range from $52.7 to $192.1 million in the first year. In subsequent years, the lower end of the range is projected to increase from $31.4 million to $50.2 million in total costs and transfers. The upper range of total costs and transfers is projected to increase from $176.2 million to $289.0 million.

Regulatory Familiarization

When a new rule is promulgated, all the establishments affected by the rule will need to invest time to read and understand the components of the new rule; this is commonly referred to a regulatory familiarization. Each establishment will spend resources to familiarize itself with the requirements of the rule and ensure it is in compliance.

Each home health care establishment will require about two hours of an HR staff person's time to read and review the new regulation, update employee handbooks and make any needed changes to the payroll systems. Based on our analysis of the industry and occupational data, the Department judges that each employer in HHCS and SEPD likely employs workers who could be classified as companions and therefore will need to review the proposed rule. There are about 73,000 establishments in SEPD and HHCS; assuming a mid-level HR wage of $26.79 per hour over two hours equals about $4

million for regulatory familiarization in the first year following promulgation of the rule.[59]

For independent providers, the employer is considered to be the family that hires them. Therefore, families that directly employ these caregivers will also have to review the regulatory revisions. Because the employer-employee relationship is less complex than for an agency that employs multiple workers caring for multiple clients, the Department expects the burden of regulatory familiarization will be smaller. The Department therefore assumes that each family that directly hires a caregiver will spend one hour on regulatory familiarization. The Department uses the national average hourly wage of $29.07 (loaded) to represent the opportunity cost of reviewing the regulatory revisions.[60]

The Department has found no data to support an estimate of the number of families that directly hire independent providers. The Department assumes each independent provider is hired by a single family, and therefore, because it estimates there are 206,600 independent providers, 206,600 families will incur the cost of one hour to review the revised regulations. These families incur one hour of time at an opportunity cost of $29.07 per hour for a total of about $6 million for regulatory familiarization in the first year following promulgation of the rule. The Department acknowledges this estimate is based on an assumed value and requests from commenters information or data that would allow it to better estimate the number of families that directly hire independent providers.

[59] Mid-level HR loaded hourly rate from BLS.
[60] BLS National Compensation Survey, July 2009, Hourly mean wage for full-time Civilian Worker is $22.36; the Department estimates the fully loaded wage at the hourly wage x 1.3. URL: http://www.bls.gov/eci/

Wages and Overtime[61]

Many home care workers are already covered by minimum wage and overtime provisions at the state level and will not drive additional costs related to the proposed rule. Sixteen states require minimum wage for all hours worked for most home health care workers and guarantee some type of overtime pay for home health care workers who would otherwise be excluded under the FLSA.[62] Five states and the District of Columbia require minimum wage for all hours worked but do not guarantee overtime.[63] Twenty-nine states do not require minimum wage or overtime. Table 3-1 summarizes the wages for PCA and HHA occupations based on state level minimum wage and overtime coverage.

Table 3-1. Summary of Wages by State Minimum Wage and Overtime Coverage for HHAs and PCAs.

Area name	Employment	Hourly Wages		
		Minimum 10th Percentile Wage	Weighted Average Median Wage	Maximum 90th Percentile Wage
All States	**1,585,990**	**$6.79**	**$9.71**	**$20.61**
States with MW and OT				
Total	780,480	$7.32	$10.39	$20.61
PCA	320,010		$10.38	
HHA	460,470		$10.41	
States with MW but no OT				
Total	120,610	$7.20	$9.85	$16.40
PCA	30,700		$9.95	
HHA	89,910		$9.75	
States without MW or OT				
Total	684,900	$6.79	$8.90	$18.76
PCA	280,060		$8.49	
HHA	404,840		$9.30	

Source: BLS OES, 2009; Note: based on the hourly wage percentiles, the minimum wage paid to workers is below the Federal minimum wage in some states with minimum wage

[61] These costs to employers are also transfer payments that will benefit employees. See Benefits, below.
[62] California, Colorado, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, Pennsylvania, Washington, and Wisconsin. NELP, 2011 and SOL internal analysis.
[63] Arizona, Nebraska, North Dakota, Ohio and South Dakota. NELP, 2011.

laws.

In order to define the subset of workers from the table that will be directly affected by the minimum wage and overtime components of the proposed rule, the Department made three primary calculations: (1) removed from the data set those workers not currently employed as exempt companions (those providing services in facilities rather than homes); (2) added employees of tax exempt organizations in states with overtime coverage to the set of workers without state-level overtime coverage (as they are sometimes exempt from the state overtime laws); and (3) identified the number of workers currently receiving less than the federal minimum wage ($7.25 per hour).

The data presented in Table 3-1 do not differentiate the workers who provide services in the homes of clients (eligible for companionship services exemption) and those that provide services primarily in facility settings (not eligible for companionship services exemption). To identify agency-employed HHAs and PCAs likely to be providing services in facilities and exclude them from the estimation of costs, the Department examined the BLS National Employment Matrix of industries for each occupation. Based on the description of the industry employing the HHA or PCA, the Department made a judgment of whether the actual services were being provided in a facility or in a private home; then, the number of workers likely to be providing services in the home were summed and compared to the total number of workers in the occupation to estimate the percent of that occupation providing services in the home. Table 3-2 summarizes the data as well as the determination of whether the industry would be home or facility-based. This percentage, approximately 80 percent of PCAs and 45 percent of HHAs, is used to adjust the number of workers below minimum wage and the number of workers

without overtime pay used in the more detailed calculations described below. By definition, the Department assumes that 100 percent of PCAs and HHAs working as independent providers work in the home setting.

Table 3-2. Summary of Industries Employing HHAs and PCAs in 2008 and Likelihood of the Aide Working in a Home or Facility.

Industry	HHA		PCA	
	Employment (1000)	Facility or Home	Employment (1000)	Facility or Home
Total, All workers [a]	**1**	**100%**	**1**	**100%**
Home	*0.449172577*	*45%*	*0.801039861*	*80%*
Facility	*0.550827423*	*55%*	*0.198960139*	*20%*
Total, All workers	100	Home	100	Home
Accounting, tax preparation, bookkeeping, and payroll	0.06	Facility	0.15	Facility
Activities related to real estate	NA	NA	0.06	Facility
Child day care services	0.07	Facility	0.41	Facility
Civic and social organizations	NA	NA	0.11	Facility
Community care facilities for the elderly	15.34	Facility	NA	NA
Community food and housing, and emergency and other relief services	0.1	Facility	0.28	Facility
Educational services, public and private	0.25	Facility	0.18	Facility
Employment services	2.16	Facility	1.84	Facility
Fitness and recreational sports centers	NA	NA	0.01	Facility
Grant making and giving services	NA	NA	0.28	Facility
HHCS	30.94	Home	27.9	Home
Hospitals, public and private	2	Facility	0.61	Facility
Hotels, motels and other traveler accommodations	NA	NA	0.03	Facility
Lessors of real estate	0.04	Facility	0.2	Facility
Local government, excluding education and hospitals	1.33	Facility	NA	NA
Management of companies and enterprises	0.14	Facility	0.54	Facility
Management, scientific, and technical consulting	NA	NA	0.04	Facility
Nursing care facilities	5.73	Facility	0.39	Facility
Offices of all other health practitioners	0.06	Facility	0.06	Facility
Offices of mental health	0.04	Facility	0.01	Facility

practitioners (except physicians)				
Offices of physical, occupational, and speech therapists, and audiologists	0.11	Facility	0.05	Facility
Offices of physicians	0.24	Facility	0.07	Facility
Other ambulatory health care services	0.05	Home	NA	NA
Other financial investment activities	NA	NA	0.03	Facility
Other investment pools and funds	NA	NA	0.02	Facility
Other personal services	NA	NA	0.41	Home
Other residential care facilities	2.18	Facility	0.4	Facility
Outpatient mental health and substance abuse centers	0.27	Facility	0.22	Facility
Personal care services	NA	NA	0.07	Home
Residential mental health and substance abuse facilities	2.16	Facility	0.24	Facility
Residential mental retardation facilities	16.9	Facility	3.04	Facility
SEPD	12.3	Home	28.12	Home
Social advocacy organizations	0.05	Facility	0.97	Facility
State government, excluding education and hospitals	1.91	Facility	NA	NA
Unpaid family workers	NA	NA	0.05	Home
Vocational Rehabilitation	1.92	Facility	3.78	Facility

Source: BLS 2008 National Employment Matrix; note that employment does not sum to the total provided by BLS, the percent of the occupation employed in the home versus a facility is calculated based on the actual sum of the number appearing in the table.
[a] Note: this excludes self-employed workers and those employed in private households because they will be added to the population of affected workers separately.

It is important to note that the determination of whether the industry is home- or facility-based is an estimate; some industries that appear to provide services primarily in a nursing facility, for example, may employ a few aides who provide services in the homes of clients to assist with transitioning of the client from the facility back to their home. Also, some industries that appear to provide services primarily in the home, HHCS for example, may also employ aides that work primarily in facilities.

Next, the workers in the states with minimum wage and overtime pay are, in general, already receiving at least the minimum wage and some form of overtime premium for

hours worked beyond 40 hours and do not need to be included when calculating the costs associated with additional wages resulting from the application of the federal minimum wage or payment of an overtime premium. The exception is for workers employed by public agencies, non-profit organizations, and other tax exempt entities who are exempt from many of the applicable state laws. To account for these workers, the Department used the 2007 Economic Census to estimate the proportion of workers in those states who are employed in establishments exempt from Federal income tax; this proportion was multiplied by the number of workers in each state to estimate the number of workers likely to be employed by an employer not covered by the state level laws related to minimum wage and overtime.[64] These workers were added to the total number of workers without overtime coverage in order to estimate the costs of providing overtime pay to workers under the proposed rule. States vary widely in terms of exemptions from minimum wage and overtime rules and not all states have these types of exemptions; as a result, this approach results in an overestimate of the number of workers who will receive additional overtime wages as a result of the proposed rule. The Department judges that this is the best available method to estimate these additional workers given available data.

The Department then analyzed the 2009 BLS OES data on PCA and HHA wages by percentile to identify those workers receiving less than the federal minimum wage (usually those in the 10^{th} and 25^{th} percentiles in states without minimum wage coverage).

Finally, due to lack of data, the Department selected the assumptions it would use to analyze independent providers directly employed by families. The Department assumes

[64] The Department used a proportion of 100 percent for workers in New York to account for the fact that New York law establishes an overtime premium for these workers of one and one-half times the minimum wage (rather than the workers regular rate). This produces an overestimate of the number of workers who will receive additional overtime pay as a result of the proposed rule.

that independent providers: (1) generally will not be eligible for overtime wage premiums, and (2) earn less than the current federal minimum wage in the same proportion as agency-employed caregivers.

To be eligible for the overtime wage premium, an independent provider would have to work more than 40 hours per week for the same employer (i.e., family); an agency-employed caregiver is eligible if he or she works more than 40 hours for the agency regardless of the number of families visited. Thus, the Department believes that independent providers are much less likely to be eligible for the overtime premium than agency-employed workers; those independent providers who work more than 40 hours per week are likely to be employed by more than one family.

By assuming that the proportion of independent providers earning less than the federal minimum wage is identical to that for agency-employed caregivers, the Department implicitly assumes independent providers work in similar patterns as agency-employed caregivers. That is, independent providers are distributed across states in the same proportion as agency-employed caregivers, and are as likely to earn less than minimum wage as those employed by agencies.

Table 3-3 summarizes the number of workers estimated to be directly impacted by the minimum wage and overtime provisions of the proposed rule. These numbers reflect the adjustments discussed above that account for employees of tax-exempt organizations not covered by their state's overtime requirements and for the percent of workers likely to be employed in a home versus a facility. These estimates are described in more detail in the following sections.

From the initial total of 1.59 million agency-employed workers, the Department estimates 934,000 are employed in homes as exempt companions. Of all agency-employed PCAs and HHAs, the Department estimates that 738,000, almost 47 percent are unlikely to be covered by current overtime provisions[65] and 31,000 (1.9%) are paid less than the federal minimum wage.

Since 3.9 percent of agency-employed PCAs earn less than minimum wage, the Department assumes 3.9 percent of the 188,500 PCA independent providers also earn less than minimum wage, about 7,350 caregivers. Similarly, because 0.7 percent of agency-employed HHAs earn less than minimum wage, 0.7 percent of the 18,100 HHA independent providers, about 120 workers, also earn less than minimum wage.

Table 3-3. Summary of Workers that are directly impacted by proposed rule.

Affected Workers	Number of Workers	Source
Agency-employed PCA and HHA	**1,585,990**	BLS 2009 OES; State-level occupational employment and wages for SOC 39-9021 and 31-1011
PCA	630,770	
HHA	955,220	
Percent PCA and HHA working in homes		BLS 2008 National Employment Matrix for SOC 39-9021 and 31-1011
PCA	80.1%	
HHA	44.9%	
Number of PCA and HHA working in homes		Total Workers multiplied by percent working in homes; BLS 2009 OES and 2008 National Employment Matrix.
PCA	505,272	
HHA	429,059	
Total	**934,331**	
Workers without OT Coverage		
Number of PCA and HHA in States without OT Coverage	290,089	Sum of employees working in homes in selected states; BLS 2009 OES
Number of PCA and HHA in NY	227,100	Employees working in homes in NY; BLS 2009 OES
Number of PCA and HHA in public agencies and nonprofits in states with OT	220,589	Total workers in states with OT laws multiplied by proportion of workers in state employed by tax-exempt organizations; BLS 2009 OES and 2007 Economic Census

[65] The total number of workers without overtime coverage does not include the 367,000 providers in California because they are currently covered by an overtime provision under a collective bargaining agreement. If the terms of that agreement change, then costs will be impacted.

Total workers without OT coverage	***737,779***	
Workers below Minimum Wage ***Number of PCA and HHA worker below minimum wage***	***30,955***	Number of workers with wage below $7.25; BLS 2009 OES. 3.9% of PCA, 0.7% HHA.
Independent Providers employed by families	**206,600**	BLS 2008 National Employment Matrix for SOC 39-9021 and 31-1011 Total number of workers multiplied by percent of agency-employed PCA and HHA that are paid below minimum wage.
PCA	188,500	
HHA	18,100	
Independent Providers below MW		
PCA	7,345	
HHA	121	

Minimum Wage

Based on BLS data describing the wages of PCAs and HHAs by percentile, there are 14,200 HHAs and 30,700 PCAs in 13 states where the minimum wage is below the federal minimum wage of $7.25. Approximately 32,600 of those workers are providing services in homes rather than facilities (85 percent multiplied by 30,700, plus, 46 percent multiplied by 14,200), and therefore are receiving only their states' minimum wage. The average wage of these workers is $7.02 per hour. As a result of the proposed changes to the companionship exemption, these workers will receive an additional $0.23 per hour. Based on available data on the number of hours worked by PCAs and HHAs, drawn from several nationally representative surveys, the Department judges that 35 hours per week is a reasonable upper-bound assumption of the average number of hours worked per week. Assuming that each of these workers is employed for 52 weeks per year, and works an average of 35 hours per week[66] then the additional cost of wages paid to these workers will be approximately $13.0 million in the first year. Review of BLS data

[66] Seavey and Marquand, 2011, pgs. 61-64. Available at: http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf

suggests that the number of workers earning less than minimum wage should be negligible in subsequent years.[67]

Since the Department assumes all independent providers are employed by families, then all of the estimated 7,350 PCAs and 120 HHAs earning less than the minimum wage provide service in homes, and no further adjustment to these numbers is necessary. If these 7,470 caregivers also receive an additional $0.23 per hour to raise their wage to the federal minimum, and work an average of 35 hours per week, then the additional cost of wages paid to these workers will be approximately $3.1 million in the first year. With no evidence to the contrary, we maintain our working assumption that wages for self-employed caregivers track those of agency-employed caregivers.

Overtime

Limited data exist on the amount of overtime worked by this population. A PHI analysis of the U.S. Census Bureau's Current Population Survey, Annual Social and Economic Supplement (ASEC) on home health care workers found 8 to 15 percent of PCAs and HHAs may work overtime. Among home health aides, 8 percent worked more than 40 hours per week, and 2 percent worked more than 50 hours per week; 15 percent of personal care attendants appeared to work more than 40 hours per week, although PHI believes this may be an overestimate based on the 2010 ASEC supplement that suggests that approximately 42 percent of aides in HHCS report working full-time year round. [68]

A significant overtime pay issue in this industry is associated with overtime pay for the care of patients requiring 24-hour services. Attending staff may be eligible for pay up

[67] BLS, Occupational Employment Statistics Survey, by state, 2000-2010. Available at URL: http://stats.bls.gov/oes/.

[68] Seavey and Marquand, 2011, pgs. 61-64. Available at: http://www.directcareclearinghouse.org/download/caringinamerica-20111212.pdf

to 16 of every 24 hours or even more (if the staff is not provided a bona fide sleep period). The City of New York and New York State Association of Counties filed an amicus brief with the U.S. Supreme Court in Long Island Care at Home, Inc. v. Coke.[69] The brief asserted that changing the FLSA companionship services exemption would significantly increase the cost to the City and State for providing home healthcare services. The brief included an estimate of the increased costs. The additional costs for home health care workers in New York City attending patients requiring 24-hour attendance is by far the largest component of these costs, exceeding the Department's estimate of nationwide overtime for all workers in all states not currently covered by overtime.

Unfortunately the brief does not adequately describe how the cost estimates were arrived at, nor does it provide estimates of the number of patients requiring 24-hour care or the workers caring for them. The numbers presented in the brief suggest over 33.6 million hours of annual overtime are worked just to care for patients requiring 24-hour care plus an additional 14.6 million hours of overtime hours are worked to care for other patients.[70] This exceeds by 37 percent the total amount of overtime the Department estimated for the 34 states and Washington, D.C. that do not currently require overtime pay, based on estimates of hours worked derived from a nationwide, statistically

[69] 551 U.S. 158 (2007). Brief of Amici Curiae City of New York and New York State Association of Counties in Support of Petitioners.

[70] The incremental cost of requiring overtime pay under this regulation is the difference between the current hourly rate paid for home health care workers, and the rate that would be paid if this regulation is promulgated (i.e., the overtime differential) applied to hours worked in excess of 40 hours per week. If straight time pay is currently about $10 per hour, the incremental cost will be $5 per hour. New York City projects the rule will cost $168 million per year for care of patients requiring 24 hour care; $168 million divided by $5 suggests that roughly 33.6 million overtime hours per year are worked in New York City alone to care for these patients.

representative sample.[71] Furthermore, this sample, from the Current Population Survey Annual Social and Economic Supplement, should reflect all hours worked, including that of home health care workers caring for patients requiring 24-hour care. In addition, the need to provide a patient with 24-hour care does not necessarily result in 72 hours of overtime per week. Maintaining continuity of care does not require a single care giver in attendance for the entire week; service can be provided with adequate continuity of care by two or four workers.[72] Therefore, because the brief does not explain the basis for the numbers, the Department has not relied upon those estimates, but rather has generally relied upon nation-wide data from BLS in developing this economic impact analysis.

BLS data show there are about 492,000 total home health care workers in facilities and private homes in states without state-mandated overtime coverage, plus 143,000 workers employed in New York, and an additional 136,000 workers employed by tax-exempt organizations in states with overtime coverage who are not eligible for coverage. In total, the Department estimates that there are 770,445 workers without overtime coverage that will be eligible for it as a result of the proposed rule.

Based on the PHI analysis of ASEC data on overtime worked in this industry, the Department calculates that if 10 percent of these 770,445 home health care workers are employed 45 hours per week (5 hours of overtime), and an additional 2 percent are employed 52.5 hours per week (12.5 hours of overtime), then about 30 million hours of overtime are worked per year. Using the weighted median wage of $9.51 per hour, these workers would earn an overtime premium of $4.75 per hour. Under these assumptions the additional cost of overtime pay would be approximately $143 million per year absent

[71] The PHI analysis is based on the U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic (ASEC) Supplement.
[72] Elsas & Powell, 2011.

changes to employment practices that could reduce or even eliminate overtime for these employees.[73]

As described above, the Department does not expect independent providers to be affected by overtime provisions. It expects few, if any, of these caregivers work more than 40 hours per week for the same family.

Market Response to Overtime Requirement

It is highly unlikely that agencies will simply accept overtime costs without changing operating and staffing policies. Currently, agencies have little incentive to manage overtime because hours worked in excess of 40 per week are paid at the same rate as hours less than 40 per week. Because overtime hours will now cost agencies more, they will have an incentive to manage those hours better to reduce costs.

At least three possible agency responses to overtime pay requirements can be identified. First, the agency might manage existing staff to reduce overtime hours while maintaining the same caseload and staffing levels. However, there is little evidence on which to predict how agencies might reorganize staff time to support the same caseload. It seems doubtful that many agencies can support their caseload without at least some overtime payments, but it is unclear how much overtime might be reduced. In addition, the time spent reorganizing staffing plans is not costless. In this scenario agencies will incur opportunity costs for managerial time in addition to overtime pay, even if management pay is unchanged.

Second, as suggested in the City of New York's amicus brief, agencies might choose not to allow staff to exceed 40 work hours per week.[74] After the Court of Appeals for the

[73] If the 367,000 providers in CA that currently receive overtime coverage under the terms of a collective bargaining agreement lose that coverage due to a change in the terms, the additional costs of overtime would be approximately $75 million under the same assumptions.

Second Circuit concluded in Coke that home health care workers were entitled to overtime pay, the experience of New York City indicates this might be a common response in some regions. Such an approach will require increased staffing to cover the existing caseload. The New York City experience suggests it became common for staff that worked more than 40 hours per week at a single agency to continue to work more than 40 hours per week, but for multiple agencies.[75] For example, a home health care worker might work perhaps 25 hours per week at two different agencies, thus not becoming eligible for overtime pay despite working 50 hours per week. Once again, agencies will incur additional managerial costs as they hire and manage additional staff. Employees that begin to work for more than one agency will also incur opportunity costs as they coordinate their schedules with multiple agencies. Finally, agencies might increase staffing by hiring new workers; depending on the tightness of the labor market, this might necessitate increasing hourly wages to attract new workers.

The third scenario comprises a mix of the first and second approach. Neither of those approaches is costless to agencies, therefore, agencies will weigh the cost of hiring additional workers with the cost of paying overtime to existing workers to determine the optimal mix of overtime and new hires appropriate to their circumstances. Agency caseload, current staffing patterns, the cost of hiring new workers, and managerial preferences for staffing mix will affect the final decision.

One factor that may help determine how many employees currently exceeding 40 hours of work per week would receive overtime pay compared to having their hours reduced below 40 per week is the potential for existing workers to absorb additional

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[74] Brief of Amici Curiae City of New York. 2007.
[75] Elsas & Powell, 2011.

hours without exceeding 40 hours per week. Available data suggest many employees are working significantly less than 40 hours per week and at least some of those workers are interested in working additional hours. As has been mentioned, studies show that HHAs and PCAs work, on average, 35 hours per week at most, and approximately 45 percent of workers in HHCS work part-time.[76] In addition, the 2010 CPS ASEC asked part-time workers why they did not work full-time; 22 percent of aides indicated they could only find part-time work and 18 percent stated they worked part-time due to business conditions. Thus potentially 40 percent of part-time aides might be interested in increasing their hours worked if more hours were available.

This suggests that of 1.59 million PCAs and HHAs, approximately 720,000 are part-time, and 288,000 might be interested in increasing their hours worked. Employees in this industry currently average at most 35 hours worked per week; if each of the 288,000 part-timers that might like to work additional hours increased their average hours worked by 1.8 per week, they could absorb the estimated 26.8 million hours of overtime currently worked without exceeding 40 hours per week themselves. Not all employers will be able to redistribute hours to interested part-time workers in this way, and it may be difficult for agencies to adjust worker schedules to come close to, but not exceed, 40 hours due to the nature of the work; the types of services they provide do not necessarily fit into one-hour increments. However, those employers who can adjust schedules and redistribute hours can be expected to decrease overtime costs significantly.

Travel Time

The FLSA requires that employees who, in the normal course of work, travel to more than one worksite during the workday be paid for travel time between each worksite. (If

[76] PHI, 2010a. p. 35. HHS, 2011. P.26.

the home health care worker travels to the first client directly from home, and returns directly home from the final client, travel time for the first trip and last trip generally are not eligible for pay.) It is clear that at least some home health care workers travel between clients and are thus eligible to be paid for that time. However, the Department has been unable to find evidence concerning how many workers routinely travel as part of the job, the number of hours spent on travel, or what percentage of that travel time currently is compensated.

New York City's amicus brief does suggest, however, that projected travel costs would be about 19.2 percent of the size of overtime costs.[77] With no other data available, this ratio seems reasonable to estimate potential travel costs. A number of qualifications apply to the use of this ratio. First, there is anecdotal evidence that agencies that operate in the city make little effort to minimize travel on the part of their workers; since travel is "free" to the agency, there is little incentive to manage travel time. Second, because there is no explanation of how either overtime or travel time estimates were generated, a closer examination of the data might change either or both estimates.[78] Third, it is unclear how work and travel patterns in New York City apply to the rest of the country. For example, anecdotal evidence suggests that home health care workers in rural areas might have to travel further between clients, but their typical caseload patterns and total travel time are unknown. A survey of 131 home health care workers in Maine found companions traveled between 0 to 438 miles per week for an average unreimbursed mileage of 45

[77] Brief of Amici Curiae City of New York. 2007.
[78] Thus, it is plausible that a modification in the assumptions used to generate one estimate might also affect the second estimate. The ratio of travel time to overtime might remain relatively stable even if the absolute values of the estimates change.

miles per week. One survey participant's comment was compelling: "I had to give up my other clients because the price of gas and low wages I wasn't making ends meet. [79]

The Department expects no independent providers will be affected by the travel time provision. Although the FLSA requires that employees who travel to more than one worksite during the workday be paid for travel time between each worksite, in the case of independent providers, any travel between work sites most likely represents travel from one employer to another, not travel between sites for the same employer. Therefore the Department anticipates independent providers will not be eligible for travel costs.

Subject to the qualifications described above, using New York City's 19.2 percent of overtime figure, the Department estimates that the requirement to pay travel time under the FLSA might add approximately $26.7 million per year to home health care agency costs. [80] Because the Department has assumed that travel costs will maintain a constant proportion to overtime pay (as calculated under Scenario 1), we project that travel pay will increase from $27.8 million to $45.8 million from year 2 through year 10.

Market Response to Travel Time Requirement

As a result of this provision, agencies should have significant incentive to reduce travel between clients for their employees, and therefore costs. It is difficult, however, to predict the potential magnitude of the cost reduction. It might be difficult to reduce travel

[79] Ashley, A., Butler, S., Fishwick, N. Home care aide's voices from the field: Job experiences of personal support specialists. The Maine home care worker retention study. *Home Healthcare Nurse*, July/August 2010, 28(7), 399-405.

[80] It is unknown whether travel hours will be paid at straight time or overtime rates; this will vary according to the circumstances of the individual worker. If we assume all travel hours are overtime hours, and are paid at approximately $15 per hour, then the $31 million in incremental travel costs suggests about 2.1 million hours per year are spent in travel. If we assume all travel hours are straight time hours, and are paid at approximately $10 per hour, then the $31 million in incremental travel costs suggests about 3.1 million hours per year are spent in travel.

due to client preferences for specific caregivers, or the geographical dispersion of clients (especially in rural areas).

Agencies might also find alternative methods to reduce the travel costs it pays to employees without reducing actual travel time. For example, an agency might be able to reduce its employees' hourly wage, but increase hours paid by including travel time in such a way that employees' take-home pay is left unchanged. There are, however, some constraints that might limit agencies' ability to utilize such a strategy. First, employees must earn at least the federal minimum wage for all hours worked, including travel time, after this policy is implemented. Second, agencies will expend managerial resources implementing such a policy, which may at least partially offset the savings from reduced wages. Third, management frequently has multiple goals, some of which might conflict with such a policy. If, for example, newer employees are paid a wage closer to the federal minimum, then their hourly wages might be reduced a lesser amount than more senior staff. This might conflict with the agencies' desired pay scale, as well as other goals such as employee retention.

Therefore, although the Department anticipates travel will be reduced as a result of the proposed rule, it cannot predict the magnitude of this reduction. First, there may be some minimum level of necessary travel that is irreducible. Second, although agencies have incentive to more carefully manage costs associated with employee travel, they might be able to do so in such a way that agencies avoid increased costs, but results in little reduction in travel by their employees.

Live-in Domestic Staff

The proposed rule would limit the application of the overtime exemption contained in § 13(b)(21) of the Act to the individual, family or household employing the live-in domestic worker. Third-party employers would no longer be entitled to claim the exemption. In addition, the proposed rule would require employers of live-in domestic workers to maintain an accurate record of hours worked, rather than simply keeping a copy of the agreement made by the employer and employee covering hours of work. The cost to employers of the proposed recordkeeping requirement, discussed more fully in the Paperwork Reduction Act section of this preamble, is estimated to be $22,580,605 (which reflects the amount for the entire information collection-approximately $3,059,650 of which stems from this NPRM). The Department has been unable to identify current data to estimate the number of live-in domestic workers employed by third-party agencies, but based on historical data, we do not expect the impact of the proposed change concerning third-party employment to be substantial. Although the Department has estimated the number of live-in domestics for purposes of the Paperwork Reduction Act (PRA), we have not included such data in the economic analysis as the Department relied upon aged data for the PRA section. The Department utilized a 1979 study of Domestic Service Employees which incorporated 1974 data and assumed for purposes of the PRA that a similar percentage of the current domestic worker population is employed in live-in domestic work today. The Department specifically invites comments and data on the number of live-in domestic workers and their employers who may be subject to this rule.

Total Transfers

Due to the continuum of different responses to the proposed regulation, the Department analyzed three possible scenarios with respect to overtime. One approach assumes the agency pays employees the overtime premium for all overtime hours worked. Conversely, the employer might change scheduling practices to avoid overtime costs and hire additional workers as necessary to work the extra hours. The final approach is modeled as a combination of the first two, half of employers pay overtime as in the first scenario and half of employers hire more workers, as in the second scenario. As described above, additional managerial costs to agencies might occur as a result of changes in staffing; the Department has no basis for estimating these costs, but believes they are relatively small. Therefore, they are not included in the three scenarios.

The three scenarios in rank order from highest to lowest amount are:

- *OT Scenario 1:* The Department assumes agencies make no adjustments to staffing and pay employees the overtime premium for all hours worked in excess of 40 per week.
- *OT Scenario 2:* The Department assumes agencies make a partial adjustment to staffing; overtime pay is reduced, but not eliminated, by hiring some additional staff or increasing hours to part-time workers. For the purposes of this estimate, the Department assumes agencies evenly split the current overtime hours between current workers (who will thus work 50 percent of the overtime hours they currently work), and new workers (who will not work any overtime hours).

- *OT Scenario 3:* The Department assumes agencies ban overtime and increase staffing to ensure no employee works more than 40 hours per week. In addition, it is assumed that additional staff can be hired at the current going wage rate.

Table 3-4 presents an overview of the total estimated transfers of this rule where the scenarios represent a range of potential outcomes and actual transfers will depend on the response of employers to the proposed rule.

Table 3-4. Summary of Transfers

Transfer Components	Total Transfers ($ mil.)	Comments
Minimum Wages to Agency-employed Workers	$13.0	
Minimum Wages to Independent Providers	$3.1	
Travel Wages	$26.7	
Overtime Scenarios		
OT1	$139.3	
OT2	$69.7	
OT3	$0.0	
Total Transfers by Scenario		
Minimum Wage + Travel + Overtime Scenario 1	$182	Employers in states with no coverage begin paying minimum wage and overtime
Minimum Wage + Travel + Overtime Scenario 2	$112	Employers in states with no coverage begin paying minimum wage and adopt a 50:50 mix of OT pay and new hires in response to overtime requirements
Minimum Wage + Travel + Overtime Scenario 3	$43	Employers in states with no coverage begin paying minimum wage and hire new workers to cover overtime

The Department examined three scenarios representing varying agencies' potential responses to the overtime pay requirement. There is little hard evidence concerning the likelihood that each scenario might occur. However, the Department expects:

Scenario 1 is the least likely; there is no reason to believe agencies will simply continue current staffing patterns and pay workers overtime for any hours exceeding 40 per week.

Scenario 1 represents an upper bound estimate that projected transfer effects should not exceed.

Scenarios 2 and 3 are more likely to occur.[81] Agencies have alternatives to paying the overtime premium: spreading existing overtime hours to other workers, either new employees or current employees who want more hours. Thus, the Department believes the true transfer effects resulting from the overtime requirement:

- Will exceed the estimate presented as Scenario 3; agencies are unlikely to be able to perfectly spread all overtime hours. This may result from specific rigidities associated with individual agencies: an inability to divide certain cases among workers so that none exceed 40 hours; insufficient part-time staff willing to take on additional hours, or a local labor pool with workers unwilling to work at the current wage level. Scenario 3 thus represents a lower bound estimate below which projected transfers are unlikely to fall.

The degree to which actual transfer effects will be greater than or less than Scenario 2 is uncertain. However, the Department expects the lower scenario is more likely; there are multiple channels through which hours can be spread to additional workers without significantly increasing non-overtime wages. The extent to which current employees work more than 40 hours per week provides little evidence of a potential labor shortage

[81] National level quantitative analyses have produced results consistent with the Department's qualitative analysis for this labor market:
Barkume, Anthony. 2010. "The Structure of Labor Costs with Overtime Work in U.S. Jobs," Industrial and Labor Relations Review, 64(1): 128-142.
Trejo, Stephen. 1991. "The Effects of Overtime Pay Regulation on Worker Compensation," American Economic Review, 81(4): 719-40.
Trejo, Stephen. 1993. "Does the Statutory Overtime Premium Discourage Long Workweeks?" Industrial and Labor Relations Review, 56(3): 530-551.

in this industry; because most agencies are not covered by overtime requirements, they have had no incentive to manage workers in a way to avoid overtime.

Projected Future Costs and Transfer Effects Due to Industry Growth

As documented above in this analysis, the demand for home health care workers has grown significantly over the past decade and is projected to continue growing rapidly. One researcher has projected at least a 200 percent increase in demand for home health care workers over the next 40 years.[82] Therefore, the Department examined how the provisions in the proposed rule might impact a rapidly growing industry.

To estimate projected regulatory familiarization costs, the Department first estimated both the number of agencies and the number of independent providers likely to enter the market. The Department used U.S. Census' Business Dynamics Statistics to estimate an average annual firm "birth" rate of 8.6 percent of existing firms.[83] With 73,175 affected agencies in the baseline, this projects to 6,314 new agencies per year that will incur incremental regulatory familiarization costs.

The projected number of families expected to hire independent providers was calculated using U.S. Census population projections by age. Census projected that the number of individuals age 65 and older will increase from 40.2 million in 2010 to 50.8 million in 2020 (36 percent), while those age 85 and older will increase from 5.8 million to 6.6 million (15 percent) over the same time period.[84] The Department selected the midpoint of these two age groups to estimate the growth rate of the population most

[82] PHI, 2010a. p. 8. HHS, 2001. Pgs. 4, 5, and 7.
[83] U.S. Census Bureau, Center for Economic Studies. Business Dynamics Statistics: Firm Age by Firm Size. Available at: http://www.ces.census.gov/index.php/bds/bds_database_list. Accessed June 17, 2010.
[84] U.S. Census Bureau. 2008 National Population Projections. Table 2: Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050. Available at: http://www.census.gov/population/www/projections/summarytables.html. Accessed November 3, 2011.

likely requiring assistance; including all those in their mid 60s and early 70s was judged to be too inclusive and would overestimate the growth of the relevant population, while many requiring assistance might have died before the age of 85, and thus that age group would underestimate growth. This growth rate over 10 years (34 percent) was applied to the number of independent home care providers in the baseline year (206,600) to estimate that 285,900 independent providers would be supplying services by 2020, an average of 7,208 new workers per year from 2010 to 2020.

However, this estimate does not account for turnover among families hiring independent home care providers; the Department accounted for this by assuming that 50 percent of the previous year's independent home health care providers would gain a new client, and that client's family would require regulatory familiarization. Thus, on average, regulatory familiarization costs among families hiring independent providers each year was calculated at 50 percent of the previous year's providers plus 7,208.

Consistent with the baseline estimate, new agencies projected to incur regulatory familiarization costs are assumed to require two incremental hours at a rate $26.79 per hour. Families hiring independent providers are assumed to require one hour of regulatory familiarization at a rate of $29.07. Table 3-5 summarizes the estimation of projected regulatory familiarization costs.

Table 3-5. Projected Regulatory Familiarization Costs

	Agencies Requiring Regulatory Familiarization		Families Requiring Regulatory Familiarization				
Year	Number	Costs ($ mil.)	Total IPs	New IPs	Turnover	Costs ($ mil.)	Costs ($ mil.)
2009	73,175	$3.92	206,600	--	--	$6.01	$9.93
2010	6,314	$0.34	213,529	6,929	103,300	$3.20	$3.54
2011	6,314	$0.34	214,529	1,000	106,765	$3.13	$3.47
2012	6,314	$0.34	222,457	7,929	107,264	$3.35	$3.69

2013	6,314	$0.34	230,386	7,929	111,229	$3.46	$3.80
2014	6,314	$0.34	238,314	7,929	115,193	$3.58	$3.92
2015	6,314	$0.34	246,243	7,929	119,157	$3.69	$4.03
2016	6,314	$0.34	254,172	7,929	123,122	$3.81	$4.15
2017	6,314	$0.34	262,100	7,929	127,086	$3.92	$4.26
2018	6,314	$0.34	270,029	7,929	131,050	$4.04	$4.38
2019	6,314	$0.34	277,957	7,929	135,014	$4.16	$4.50
2020	6,314	$0.34	285,886	7,929	138,979	$4.27	$4.61

To estimate the number of incremental home healthcare providers that might earn an overtime wage premium or travel pay under the proposed revisions, the Department utilized BLS Occupational Outlook employment projections for 2018.[85] The Department interpolated employment data for 2011 through 2017, and extrapolated the time series through 2020 using a constant rate of growth assumption. Wage data were directly extrapolated using the time trend from 2000 through 2010. Based on these time series:

- Home Health Aide employment will increase by an average of 4.08 percent per year.[86] Median nominal wage will increase by an average of 1.66 percent per year while median real wage will increase by an average of 0.11 percent per year.[87]
- Personal Care Aide employment will increase by an average of 6.95 percent per year. Median nominal wage will increase by an average of 1.88 percent per year, and the median real wage will increase by an average of 0.33 percent per year.

Table 3-6 summarizes the projections of HHA and PCA employment and wages developed for this analysis.

[85] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2010-11 Edition*, Home Health Aides and Personal and Home Care Aides, on the Internet at http://www.bls.gov/oco/ocos326.htm (visited September 20, 2011).

[86] Total hours worked and overtime hours worked will increase at the same rate in this model.

[87] The Department adjusted nominal wages for inflation using the average increase in the PPI for Home Health Services over the last 10 years (1.55 percent).

Table 3-6. Projected Employment and Hourly Wage, HHAs and PCAs, 2009 - 2020[a]

Year	Home Health Aides				Personal Care Aides		
	Total Employ-ment (millions)	Median Wage			Total Employ-ment (millions)	Median Wage	
		Nominal	Inflation Adjusted[b]			Nominal	Inflation Adjusted[b]
2009	0.96	$9.85	$9.85		0.63	$9.46	$9.46
2010	0.98	$9.89	$9.74		0.69	$9.44	$9.29
2011	1.03	$10.21	$9.90		0.75	$9.71	$9.42
2012	1.08	$10.38	$9.92		0.81	$9.92	$9.48
2013	1.13	$10.56	$9.93		0.88	$10.13	$9.53
2014	1.18	$10.74	$9.95		0.94	$10.34	$9.58
2015	1.23	$10.91	$9.96		1.00	$10.55	$9.63
2016	1.28	$11.09	$9.96		1.07	$10.76	$9.67
2017	1.33	$11.27	$9.97		1.13	$10.97	$9.71
2018	1.38	$11.45	$9.97		1.19	$11.18	$9.75
2019	1.43	$11.62	$9.97		1.26	$11.39	$9.78
2020	1.48	$11.80	$9.97		1.32	$11.61	$9.81

[a] Derived from BLS Occupational Outlook.
[b] Estimate based on 10 year average change in PPI for Home Health Services.

The Department did not project transfer effects associated with minimum wage provisions of the FLSA on these occupations. BLS Occupational Employment Statistics on PCA and HHA wages for 2010 indicate that few, if any, workers are currently paid below minimum wage. BLS found no state in which the tenth percentile wage was below $7.25 per hour.[88]

Projected Cost Impacts

This section draws on the estimates of costs to determine the anticipated impact of the proposed regulations in terms of total cost across all industries as well as estimated cost per firm and per employee. Table 4-1 summarizes the first year costs, transfer effects and impacts of the proposed rule.

Table 4-1. Summary of First Year Impact of Proposed Changes

[88] BLS Occupational Employment Statistics, 2010 state estimates, at http://stats.bls.gov/oes/.

Impact	Amount		
Transfers	**Total ($ mil.)**		
Minimum Wages	$13.0		
Minimum Wages to Self-Employed Workers	$3.1		
Travel Wages	$26.7		
Overtime Scenarios			
OT1	$139.3		
OT2	$69.7		
OT3	$0.0		
Total Transfers by Scenario			
Minimum Wage + Travel + Overtime Scenario 1	$182.1		
Minimum Wage + Travel + Overtime Scenario 2	$112.5		
Minimum Wage + Travel + Overtime Scenario 3	$42.8		
Deadweight Loss	**Total**		
Disemployment Effect (number of workers)	505		
Amount ($)	$42,000		
Costs	**Year 1 ($ mil.)**	**Years 2 - 10 ($ mil.)**	**Annualized at 7% Real Discount Rate ($ mil.)**
Regulatory Familiarization	$3.9		
Self-employed Regulatory Familiarization	$6.0		

Table 4-2 presents the impact of regulatory familiarization costs on existing agencies and families in the first year. First year regulatory familiarization costs total $9.9 million; when annualized at a 7 percent discount rate over 10 years, total annualized costs are $1.3 million per year. Cost per agency is $54, while families employing independent providers will incur costs of $29 per family.

Table 4-2. Impact of Regulatory Familiarization Costs

Regulatory Familiarization Costs to:	Total Projected Compliance Costs ($mil.)				Cost to Employers	
	Year 1[a]	Years 2 –– 10 [b]		Annualized at 7%	Cost Per Establish-ment [a]	Cost as Percent of Revenue
Home Healthcare Agencies	$3.9	$0.30	$0.3	$0.85	$54	0.0049%
Families Employing Independent Providers	$6.0	$3.20.0	$4.0	$03.9.8	$29	[b,c]

[a] Regulatory familiarization applies to 73,175 establishments; self-employment regulatory familiarization will impact 77,900 entities.
[b] Average revenue not calculated because for the purpose of this analysis the "employer" ' is the family employing the self-employed worker; therefore, there is no revenue available.
[c] Average revenue not calculated because for the purpose of this analysis the 'employer' is the family employing the self-employed worker; therefore, there is no revenue data available.

Regulatory familiarization costs are only incurred once by an affected entity; additional regulatory familiarization costs are not incurred by these agencies and therefore do not affect their ability to bear regulatory familiarization costs. The approach to estimate regulatory familiarization costs to new entrants is discussed above in Projected Future Costs.

Market Impacts

The Department anticipates that the proposed rule will have relatively little effect on the provision of companionship services. There are almost no data, such as price elasticities of supply or demand, that can directly be use to model the market for companionship services. Furthermore, because approximately 75 percent of expenditures on home health services are reimbursed by Medicare and Medicaid, the effect of the rule depends vitally on how Medicare and Medicaid respond to the increase in the cost of providing home health services. However, despite these limitations, the Department used available data combined with best professional judgment to appropriately adjust parameter values, to project deadweight loss and disemployment effects of the proposed rule.

In this section, the Department first presents estimated costs and transfer effects for each provision of the proposed rule, along with qualitative discussion of potential market adjustments and impacts of that provision. The Department then presents the projected

deadweight loss and disemployment effects of the proposed rule using a market model framework.

The Department estimates:

- Regulatory familiarization and adjustments to managing travel and overtime are projected to cost less than $4 million in the first year, or about $54 per establishment, which is perhaps 0.005 percent of average annual establishment revenue. As noted previously in this analysis, between 8 and 15 percent of PCAs and HHAs may work overtime, and employers currently manage these issues for other occupational categories. Furthermore, while employers of PCAs and HHAs who work overtime may require more time spent in managing travel and overtime, the Department believes, on average, there should be little impact on employment attributable to regulatory familiarization costs.
- Minimum wage provisions total $13.0 million (Table 3-4), a 3.3 percent increase in wage for 31,000 affected workers employed by agencies. In addition, the Department estimates that 7,500 independent providers directly employed by families might also receive a 3.3 percent wage increase attributable to the minimum wage provisions. If the price elasticity of demand for these workers is similar to the national average price elasticity of demand for all workers (-0.3)[89], about 310 agency-employed and 74 independent providers might lose their positions because of this provision. However, because many of these services are paid by Medicare and Medicaid, demand for them might be less elastic than the overall national average; this would reduce the disemployment effect; this will be discussed in greater detail below. Furthermore, it is

[89] Hamermesh, D.S., Labor Demand. Princeton, N.J.: Princeton University Press. 1993.

likely these workers will be able to find new positions due to the overtime pay provisions and because the demand for these workers is projected to grow by 200 percent by 2050.[90]

- Projected travel costs represent a transfer of $27 million per year from agencies to employees (Table 3-4, although this might decline as agencies will now have incentive to more closely manage travel time). If these payments are spread equally over all agencies in this industry, they represent about a 0.06 percent increase in wages to employees. It is more likely that these payments will be distributed less uniformly; employees of some agencies might receive significant travel transfer effects, while others receive less.
- Transfer effects associated with overtime are most difficult to project. If Scenario 2 represents the best point estimate of overtime payments, then the $69.7 million in additional wages compose about 0.17 percent of annual wages if overtime is spread over all workers, or about 0.09 percent of average industry annual revenues if spread over all establishments. Again, it is likely that overtime payments will be distributed less uniformly in a way that is difficult to predict.

However, changes in wages are not the only determinant of how the market might tend to respond to the proposed rule; the demand for home health services, and therefore the demand for workers in this industry, also affects the market response. Conceptually, the demand for companionship services probably has two distinct components: patients covered by Medicare and Medicaid, and out-of-pocket payers. According to the Medicare Payment Advisory Commission (MEDPAC), Medicare and Medicaid accounted for 35 and 41 percent, respectively, of total spending on home health in

[90] HHS 2003, p. v.

2008.[91] Of the remaining 24 percent, out-of-pocket payers (including private insurance) are 20 percent (the remaining 4 percent is a mix of other governmental sources).[92]

Currently, Medicare will cover, without a copayment requirement, all – or almost all – of allowed payment rate for home health care services for patients eligible for Medicare payments. Thus, the demand for services by these patients is likely to be highly inelastic, and the purchase of these services is dependent primarily on need and eligibility rather than price.[93] In addition, Medicare has historically determined the payment rate to providers of these services based in part on regional market prices of inputs, which in home health care services labor constitutes 77 percent of the cost of services.[94] Because minimum wage and travel are unavoidable costs of providing these services, it seems reasonable to assume that these costs will eventually be reflected in payment rates. The impact of overtime pay on reimbursement rates is more uncertain.

Patients that pay all, or a significant share, of costs out-of-pocket might have a significantly different price elasticity of demand for home health care services. Little information is known about this market segment, including the percent of home health care patients paying out-of-pocket, or the extent to which some have private insurance to

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[91] Home Health Care Services Payment System. The Medicare Payment Advisory Commission (MedPAC). October 2010, available at: http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_HHA.pdf.

[92] US Census Bureau: Health Care and Social Assistance, Estimated Year-to-Year Change in Revenue for Employer Firms by Source, Table 8.9. Available at: http://www.census.gov/services/sas_data.html.

[93] Home Health Care Services Payment System. The Medicare Payment Advisory Commission (MedPAC). October 2010, available at: http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_HHA.pdf. Medicare, for example, does not require copayment for eligible patients.

[94] Section 1895 of the Social Security Act required that that the home health prospective payment system (HH PPS) make payment for all costs of home health services. As such, under the HH PPS, Medicare covers and pays for all home health services, including medical supplies, that are reasonable and necessary, for beneficiaries that are eligible for the Medicare home health benefit. The law requires that the HH PPS rates be updated, on an annual basis, by the home health market basket update (plus or minus any percentage legislated by Congress). CMS uses the home health market basket index, which measures (and tracks) inflation in the prices of an appropriate mix of goods and services that HHAs purchase in furnishing home health care. Medicare cost report data are used to construct the cost weights for the blended wage and benefit index. See also Home Health Care Services Payment System. MedPAC. 2010

cover costs. Because Medicare and Medicaid account for about 75 percent of total payments for home health care services, it is likely that the self-pay market segment is significantly smaller. To the extent that these patients are not covered by private insurance and pay out-of-pocket, they are likely to have a more elastic demand for services; if the prices for home health services increases, these patients are more likely to search for lower cost alternatives, including relying on family members to provide care, institutionalizing the patient (but see discussion of Medicare and Medicaid, infra, indicating that this may not occur), or accessing the grey market. However, the size of such an effect is difficult to predict on the basis of extant information.

Because incremental transfers are projected to be small relative to industry wages and revenues, and because the market for these services is dominated by government payers, the Department expects the impact of the proposed rule on the market for home health care services to be relatively small. However, to the extent that some transfers are not reimbursed by government payers, and that agencies might therefore increase price to patients, they might result in some patients seeking alternatives to the organized market for home health care services.

Deadweight Loss

Deadweight loss from a regulation results from a wedge driven between the price consumers pay for a product or service, and the price received by the suppliers of those services. In this case, the transfer of income from agency owners to agency employees through minimum wage and overtime provisions reduces agencies' willingness to provide companionship services at the current market price. Because patients and their families must now pay more to receive the same hours of service, they reduce the number of hours

of services they purchase; it is this reduction in services that causes the allocative inefficiency (deadweight loss) of the rule.

To estimate deadweight loss, the Department must estimate the reduction in services agencies are willing to provide at the current market price, the resulting increase in market price paid by patients and families, and their reduced purchases of companion services. To do this, the Department will use: (1) the current market wage and hours purchased of companion services; (2) the estimated regulatory costs and income transfers resulting from the rule; and (3) the price elasticity of demand for and supply of companion services.

As described above, the Department has estimated approximately 353,000 HHAs and 423,000 PCAs work in states without current overtime and/or minimum wage provisions or are directly employed by the home; of these, 339,000 HHAs and 399,000 PCAs are employed in agencies and are potentially affected by the overtime provisions of the proposed rule. These caregivers each provide about 35 hours per week of companion services in the home. The average hourly wage in these states is $9.85 for HHAs and $9.45 for PCAs. The Department used the number of employees affected by overtime provisions in its calculation of deadweight loss because: (1) the populations of affected workers in states without minimum wage and overtime provisions are largely overlapping and thus create potential double-counting; (2) under Scenario 2, overtime premiums are four times larger than projected minimum wage payments, and (3) spreading costs and transfers over a smaller worker population results in a more conservative estimate of deadweight loss (that is, the Department is more likely to overestimate, than underestimate deadweight loss).

The Department estimated a range of regulatory costs and income transfers depending on the assumptions made concerning business response to the regulation. As discussed above, the most probable of the three scenarios considered (Scenario 2) assumes an equal split of overtime costs between agencies, who pay at least some limited amount of overtime, and caregivers, who reduce hours worked at that agency (although they might seek additional hours to work at other agencies). Combining projected costs under Scenario 2, with the amounts due based upon the minimum wage and travel pay provisions, the Department estimated the deadweight loss of the rule based on first year compliance costs of $122.4 million. Thus, the rule might cost $166 per potentially affected worker, or approximately $0.0912 per hour assuming workers average 35 hours per week, about 0.93 percent of current hourly wage for HHAs and 0.96 percent for PCAs.

There are no econometric estimates of the price elasticity of demand or supply for companionship services. The price elasticity of demand for labor services has been estimated as -0.3 (a 1 percent increase in wages will cause a 0.3 percent reduction in hours purchased). However, it is reasonable to expect that the demand for companionship services is less elastic than the demand for general labor services because much of the cost is paid by Medicare and Medicaid. As a result, patients and family members are largely cushioned from the direct effects of changes in price for these services and are thus less likely to change their demand for them. Therefore, the Department assumes the demand for home companionship services is one-half the price elasticity of demand for general labor services, or -0.15.

The price elasticity of supply for hourly labor has been estimated at 0.1 (a 1 percent increase in wages will cause a 0.1 percent increase in hours supplied). However, among married women, that price elasticity of supply is estimated to be about 0.14; because hours worked in this labor market are primarily supplied by married women, the Department selected a value of 0.14 to use as the price elasticity of supply of home healthcare services in this analysis.

Based on these price elasticities of supply and demand, the estimated cost per caregiver hour, and baseline employment and wages, the Department projects that for:

- HHAs, hourly wage will increase by $0.044 to $9.89, and employment will decrease by about 227, or about 413,000 hours of companionship services annually; deadweight loss will be $18,800 annually.
- PCAs, hourly wage will increase by $0.044 to $9.50, and employment will decrease by 278, or about 507,000 hours of companionship services annually; deadweight loss will be $23,100 annually.

In addition, transfers to home caregivers will be borne by the patients and their families in the form of higher prices, and by agencies and their owners in the form of reduced income. The determination of who pays these transfers is a function of the relative price elasticities of supply and demand; with inelastic demand and labor supply, these transfers are approximately equally shared between purchasers (about 48.3 percent borne by patients, their families, and Medicare and Medicaid) and agencies (about 51.7 percent). For:

- HHAs, about $27.1 million is estimated to be paid by patients, their families, and Medicare and Medicaid; while $29.1 million is estimated to be paid by agencies and their owners in the form of reduced income.
- PCAs, patients, their families, and Medicare and Medicaid are estimated to pay about $31.9 million, and $34.2 million is estimated to be paid by agencies and their owners in the form of reduced income.

Table 4-3 summarizes both the values of the parameters used in the deadweight loss analysis and the results of the analysis.

Table 4-3. Summary of Deadweight Loss Estimation

	HHA	PCA	Total
Values Used in Deadweight Loss Analysis			
Price Elasticity of Demand	-0.15	-0.15	
Price Elasticity of Supply	.14	.14	
Baseline Hourly Wage	$9.85	$9.46	
Baseline Employment[a]	338,801	398,960	737,761
Compliance Costs ($ mil.)[b]			$122.4
Compliance Costs per Hour[c]			$0.0912
Results of Deadweight Loss Analysis			
Post-Rule Hourly Wage	$9.89	$9.50	
Post-Rule Hourly Employment	338,574	398,682	737,255
Change in Hourly Wage	$0.044	$0.044	
Change in Employment	-227	-278	-505
Deadweight Loss	$18,837	$23,096	$41,933
Percent of Costs and Transfers Paid by Purchasers[d]	48.3%	48.3%	48.3%
Costs and Transfers Paid by Purchasers ($ mil.)	$27.1	$31.9	$51.9
Percent of Costs and Transfers Paid by Employers[e]	51.7%	51.7%	51.7%
Costs and Transfers Paid by Employers ($ mil.)	$29.1	$34.2	$63.3

[a] Agency employment in states without minimum wage and/or overtime laws plus independent providers in states without minimum wage laws.
[b] Estimated sum of transfers and costs from overtime scenario 2, travel, minimum wage, and regulatory familiarization costs.
[c] Assumes each caregiver works 35 hours per week 52 weeks per year.
[d] Costs and transfers paid by purchasers in the form of higher prices; includes direct purchase of home health care services and services purchased through Medicare/Medicaid.
[e] Costs and transfers paid by employers in the form of lower profits.
Individual components may not sum to totals due to rounding.

Impact to Medicare and Medicaid Budgets

In 2009, HHS outlays for Medicare programs totaled $424 billion, and outlays in support of Medicaid totaled $251 billion.[95] Under Medicare, an estimated $18.3 billion went to home health programs, while Medicaid programs accounted for approximately another $38.1 billion (approximately $40 billion inflated to 2009 dollars) through various programs.[96] In 2008, Medicare and Medicaid accounted for nearly 75 percent of home health care services revenue; thus, the impact of the proposed rule on home health care will depend vitally on how Medicare and Medicaid respond to increased labor costs.

Although increased payments to workers associated with minimum wage, travel, and overtime provisions of the proposed rule are considered transfer effects from a societal perspective, the Department expects agencies will try to pass these transfers through to Medicare and Medicaid. Under the three overtime scenarios examined, average annualized payments range from $41.5 to $226.0 million depending on how home health care agencies respond to overtime requirements. If Medicare and Medicaid continue to pay 75 percent of home health care costs, roughly $31.1 million to $169.5 million in costs might be incurred by these government programs. These costs compose 0.06 to 0.29 percent of total HHS and state outlays for home health care programs ($58.1 billion).

[95] U.S. Department of Health and Human Services (HHS). 2011. FY 2011 Budget, available at http://dhhs.gov/asfr/ob/docbudget/2011budgetinbrief.pdf. p. 13.
[96] Id.

We invite comment on the impact of the rule of on Medicaid, Medicare, and the private market, including the impact on the affordability of home health and home and community-based services.

Projected Future Transfer Effects Due to Industry Growth

This section projects costs,, and impacts over 10 years. The Department used several key assumptions to develop these projections. First, the Department assumed that the number of home healthcare workers directly employed in the homes or employed in states without current overtime premium requirements will remain a constant percentage of total employment in those occupations between 2010 and 2020 (about 35.5 percent of HHAs and 63.3 percent of HHAs).

Second, we also maintained the assumptions that 12 percent of workers exceed 40 hours worked per week and that 10 percent of these caregivers work 45 hours per week while 2 percent work 12.5 hours of overtime per week. These overtime assumptions are identical to those used to estimate costs and transfers for 2009, while the percentages used to estimate the number of workers potentially affected in each year were calculated from the 2009 analysis.

Third, consistent with the 2009 analysis, we project two three overtime scenarios: and one for travel costs:

- Scenario 1: Employers make no adjustment to hours worked and pay all workers the overtime premium for all hours worked in excess of 40 per week.
- Scenario 2: Employers adjust schedules and/or hire additional workers to reduce overtime payment; we assume 50 percent of overtime payments can be avoided through these market adjustments.

- Scenario 3: Employers adjust schedules and/or hire additional workers to eliminate overtime payments.

Finally, we continue to estimate travel costs 19.2 percent of Overtime Scenario 1 costs.

The Department excluded potential transfer effects associated with the minimum wage provision from the projections because the current number of workers earning less than the minimum wage is relatively small and will decline steadily as nominal wages increase. Although the Department expects that the parameters used in this analysis will not remain constant, it has no information on which to base estimates of how these key variables might change over time. Therefore, maintaining the assumptions used in the analysis for 2009 provide the best basis for projecting future costs and transfer effects.

Based on the data and assumptions described in this section, and the employment and wage projections in Table 3-6, Table 4-4 presents the Department's projections through 2020 of overtime and travel payments attributable to the revisions to the companionship regulations FLSA proposed in this notice.

Table 4-4. Projected HHA and PCA Overtime Hours, Overtime Pay and Travel Pay Attributable to Proposed Revisions, 2010 – 2020[a]

Year	Overtime Hours Worked (millions)[b]		Overtime and Travel Payments (millions)[c]		
	Scenario 1	Scenario 2	Scenario 1	Scenario 2	Travel/ Scenario 3
			Nominal Dollars		
2010	30.5	15.3	$147.1	$73.6	$28.2
2011	32.8	16.4	$162.7	$81.3	$31.2
2012	35.0	17.5	$177.2	$88.6	$34.0
2013	37.3	18.6	$192.2	$96.1	$36.9
2014	39.5	19.8	$207.7	$103.9	$39.9
2015	41.8	20.9	$223.6	$111.8	$42.9
2016	44.0	22.0	$240.0	$120.0	$46.1
2017	46.3	23.2	$256.8	$128.4	$49.3
2018	48.6	24.3	$274.0	$137.0	$52.6

2019	50.8	25.4	$291.8	$145.9	$56.0
2020	53.1	26.5	$309.9	$155.0	$59.5
			Inflation Adjusted Dollars		
2010	30.5	15.3	$144.8	$72.4	$27.8
2011	32.8	16.4	$157.8	$78.9	$30.3
2012	35.0	17.5	$169.3	$84.6	$32.5
2013	37.3	18.6	$180.8	$90.4	$34.7
2014	39.5	19.8	$192.4	$96.2	$36.9
2015	41.8	20.9	$204.0	$102.0	$39.2
2016	44.0	22.0	$215.6	$107.8	$41.4
2017	46.3	23.2	$227.2	$113.6	$43.6
2018	48.6	24.3	$238.8	$119.4	$45.8
2019	50.8	25.4	$250.3	$125.2	$48.1
2020	53.1	26.5	$261.9	$130.9	$50.3

[a] Calculations based on employment and wage data in Table 3-6 and specified assumptions.
[b] Under Scenario 3, no overtime payments are incurred.
[c] Because overtime payments under Scenario 3 are zero, total payments under Scenario 3 are identical to travel payments. Total payments under Scenarios 1 and 2 are equal to overtime payments under that scenario plus travel payments.

The Department projects that paid overtime hours will increase from 30.5 million to 53.1 million between 2010 and 2020 with a consequent increase in overtime pay from $147.1 million to $309.9 million assuming employers make no adjustment to overtime work patterns (Scenario 1). In inflation- adjusted dollars, overtime pay is projected to increase from $144.8 million to $261.9 million. Assuming employers are able to cover 50 percent of overtime hours through scheduling changes and/or hiring additional workers (Scenario 2), the projected increase is half that of Scenario 1. Travel pay is projected to increase from $28.2 million to $59.5 million in nominal dollars ($27.8 million to $50.3 million in inflation-adjusted dollars) over that same period.

To place these projected future transfer effects resulting from the proposed rule in context, the Department compared nominal transfer effects to projected Medicare spending over the same period. The Centers for Medicare & Medicaid Services report

that in 2010 Medicare expenditures totaled $522.8 billion, $19.1 billion of which was spent on the provision of home health care services, and that annual Medicare expenditures are projected to increase to $932.1 billion by 2020.[97] Assuming that expenditures of home health services as a percent of total Medicare expenditures remains constant, annual home health care expenditures might increase to $34.1 billion by 2020.[98]

However, the total overtime and travel payments projected to result from the proposed rule will not paid by Medicare. On average, about 51.7 percent of projected costs and transfer effects are expected to be paid by providers in the form of lower profits (see discussion of deadweight loss for details). Further, only about 75 percent of payments for home health care services are attributable to Medicare and Medicaid; patients and their families and their private insurance account for 20 percent of payments. About 5 percent is accounted for by a mix of other governmental programs.

After adjusting projected overtime and travel transfer effects, the Department expects incremental Medicare payments attributable to the rule will increase from about $59.8 million in 2010 to $133.8 million in 2020 under Scenario 1, and from $34.7 million to $77.6 million under the more probable Scenario 2, and from $9.6 million to $21.5 million under Scenario 3 (as discussed above, the Department expects the market response to the rule will most likely lie somewhere between Scenario 2 and Scenario 3). These incremental payments compose no more than 0.4 percent of projected Medicare Home Health Care expenditures under Scenario 1, and 0.23 percent of those expenditures under

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[97] The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Washington, D.C., May 13, 2011. 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Accessed at: https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf, October 7, 2011.

[98] The report indicates that expenditures of home health services as a percent of total Medicare expenditures are expected to increase by a small amount over that period.

Scenario 2, and 0.06 percent under Scenario 3. Table 4-5 summarizes projected Medicare budgets, incremental payments attributable to the proposed rule, and those payments as a percent of Medicare Home Health Care expenditures from 2010 through 2020.

Table 4-5. Projected Overtime and Travel Pay as Percent of Medicare Home Health Care Expenditures

Year	Medicare Expenditures (billions)[a]		Adjusted Overtime & Travel Payments in Nominal Dollars (millions)[b]			OT & Travel as % Medicare Home Health Care		
	Total	Home Health Care	OT 1 + Travel	OT 2 + Travel	OT 3 + Travel	OT 1 + Travel	OT 2 + Travel	OT 3 + Travel
2010	$522.8	$19.1	$59.8	$34.7	$9.6	0.31%	0.18%	0.05%
2011	$522.8	$19.1	$63.5	$36.9	$10.2	0.33%	0.19%	0.05%
2012	$557.4	$20.4	$70.2	$40.8	$11.3	0.34%	0.20%	0.06%
2013	$572.2	$20.9	$76.5	$44.4	$12.3	0.37%	0.21%	0.06%
2014	$606.6	$22.2	$83.0	$48.2	$13.4	0.37%	0.22%	0.06%
2015	$643.4	$23.5	$89.6	$52.0	$14.4	0.38%	0.22%	0.06%
2016	$675.8	$24.7	$96.5	$56.0	$15.5	0.39%	0.23%	0.06%
2017	$716.1	$26.2	$103.6	$60.1	$16.7	0.40%	0.23%	0.06%
2018	$760.3	$27.8	$110.8	$64.3	$17.9	0.40%	0.23%	0.06%
2019	$809.6	$29.6	$118.3	$68.7	$19.1	0.40%	0.23%	0.06%
2020	$864.5	$31.6	$125.9	$73.1	$20.3	0.40%	0.23%	0.06%

[a] Total Medicare expenditures projected by CMS; Home Healthcare Expenditures extrapolated based on the percent of total Medicare expenditures in 2010.

[b] Projected payments reduced by 9.1 percent to adjust for average percent of costs paid by agencies in the form of lower profits, then reduced by 25 percent to adjust for percent of home health care purchases paid by patients and their families.

The Department also projected deadweight loss and employment impacts over 10 years. These projections are calculated maintaining the assumptions concerning the price elasticities of supply and demand discussed in the first year deadweight loss analysis, projected regulatory familiarization costs summarized in Table 3-5, and projected overtime and travel payments presented in Table 4-4. The Department's calculated deadweight loss and employment impacts over 10 years are summarized in Table 4-6.

Table 4-6. Projected Deadweight Loss and Employment Impacts

				Average Annualized Value ($ mil.)	
	Year 1 ($ mil.)	**Years 2 - 10 ($ mil.)[a]**		**3% Real Rate**	**7% Real Rate**
Regulatory Familiarization Costs					
Agencies	$3.9	$0.3	$0.3	$0.7	$0.8
Families Hiring Self-employed	$6.0	$3.2	$4.0	$3.8	$3.9
Transfers					
Minimum Wages (MW)					
to Agency-Employed Workers	$13.0	$0.0	$0.0	$1.5	$1.7
to Self-Employed Workers	$3.1	$0.0	$0.0	$0.4	$0.4
Travel Wages	$26.7	$27.8	$45.8	$35.4	$34.7
Overtime Scenarios					
OT 1	$139.3	$144.8	$238.8	$184.2	$180.7
OT 2	$69.7	$72.4	$119.4	$92.1	$90.4
OT 3	$0.0	$0.0	$0.0	$0.0	$0.0
Total Costs and Transfers by Scenario					
Reg Fam + MW + Travel + OT 1	$192.1	$176.2	$289.0	$226.0	$222.2
Reg Fam + MW + Travel + OT 2	$122.4	$103.8	$169.6	$133.9	$131.9
Reg Fam + MW + Travel + OT 3	$52.7	$31.4	$50.2	$41.8	$41.5
Deadweight Loss					
Reg Fam + MW + Travel + OT 1	$0.103	$0.080	$0.132	$0.105	$0.103
Reg Fam + MW + Travel + OT 2	$0.042	$0.027	$0.044	$0.036	$0.036
Reg Fam + MW + Travel + OT 3	$0.008	$0.002	$0.004	$0.003	$0.003
Disemployment (number of workers)					
Reg Fam + MW + Travel + OT 1	793	739	1,169	938[b]	
Reg Fam + MW + Travel + OT 2	505	435	686	555[b]	
Reg Fam + MW + Travel + OT 3	218	132	203	172[b]	

[a] These costs are a range where the first number represents the estimate for Year 2; the second estimate for Year 10.
[b] Simple average over 10 years.

Total average annualized regulatory familiarization costs, and minimum wage, overtime premium, and travel payments range from $41.5 million to $226.0 million per year based on how employers adjust to the requirement to pay overtime wage premiums. These costs and transfers are projected to cause average annualized deadweight loss ranging from $3,000 to $105,000 per year. These costs and transfers are also projected to cause disemployment impacts ranging from 172 to 938 workers per year.

Non-monetized Projected Impact

Two additional aspects of home health care services might be affected by the proposed rule. First, the proposed rule might result in increased purchases of home health care services through the informal, or "grey," market. Second, although the hours of care received by patients might be unaffected by the increased costs of care, the quality of that care might suffer (however, the quality of care also may increase due to increased professionalism and decreased turnover). These are discussed in turn below.

The Grey Market

An unknown number of patients receive home care services through more informal arrangements with care providers, sometimes called the "grey" market. Here, informal agreements are reached between the patient (or patient's family) and the caregiver regarding hours of care and hourly pay rates. Because income and payroll taxes can be avoided, services can be provided at lower cost than when provided through agencies.

The proposed rule will increase costs to home health care agencies that offer services in states where they are not required to pay the minimum wage and/or overtime pay and

an unknown percentage of those costs might be reimbursed by Medicare and Medicaid. If the costs are not fully reimbursed, home health care agencies might increase the rates they charge patients, have their profit margin squeezed, or both. If costs are passed through to patients and their families, they will have incentive to look for lower cost alternatives such as the grey market. In addition, workers who desire to work more than 40 hours per week might have opportunities to provide services through the grey market rather than work for multiple agencies. Although the proposed rule might increase incentives on both sides to use the grey market, there is no information available to project potential changes to that market.

Continuity of Care

Continuity of care "is commonly framed as being composed of provider continuity (a relationship between a patient and provider over time), information continuity (availability and use of data from prior events during current client encounters) and management continuity (coherent delivery of care from different doctors)."[99] In the home care scenario, concerns have been raised that continuity of care, specifically provider continuity, may suffer if employers opt not to pay overtime for aides who, for example, work more than 40 hours per week for a single client and instead employ other aides to also provide companionship to that client in the same workweek. Some are concerned that a break in the continuity of care may result in a reduction in the quality of care.

The Department understands that home health care involves more than the provision of impersonal services; when a caregiver spends significant time with a client in the

[99] Walraven, C., Oake, N., Jennings, A., *et al.* The association between continuity of care and outcomes: a systematic and critical review. *Journal of Evaluation in Clinical Practice*, April 2009, 947-956.

client's home, the personal relationship between caregiver and patient can be very important. Certain clients may prefer to have the same caregiver(s), rather than a sequence of different caregivers. The extent to which home health care agencies choose to spread employment (hire more companions) rather than pay overtime may cause an increase in the number of caregivers for a client; the client may be less satisfied with that care, and communication between caregivers might suffer, affecting the quality of care for the client.[100]

Although matching client and caregiver in a long-term personal relationship is the ideal for many clients, it may not be the norm. For instance, the turnover rate (those leaving and entering home care work) for workers in the home health care industry has been estimated to range from 44 to 65 percent per year.[101] Other studies have found turnover rates to be much higher, up to 95 percent[102] and, in some cases, 100 percent annually.[103] Thus, many clients already experience a sequence of different caregivers, and it is not apparent that the proposed rule will necessarily worsen the turnover rate. In fact, coverage under the FLSA may reduce turnover rates. Frequent turnover is costly for employers in terms of recruitment costs and training of new aides and also in terms of the likelihood of a reduction of quality care or not being able to provide care at all. The employee turnover rate in this industry is high because of low wages, poor or nonexistent benefits, and erratic and unpredictable hours. Job satisfaction, and the desire to remain in a given position, is highly correlated with wages, workload, and working conditions.

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[100] Brief of Amici Curiae City of New York. 2007.
[101] PHI, 2010a.
[102] Zontek, T., Isernhagen, J., Ogle, B. Psychosocial factors contributing to occupational injuries among direct care workers. *American Association of Occupational Health Nurses Journal*, August 2009, 338-347.
[103] Ashley, A., Butler, S., Fishwick, N. Home care aide's voices from the field: Job experiences of personal support specialists. The Maine home care worker retention study. *Home Healthcare Nurse*, July/August 2010, 28(7), 399-405.

Increased pay for the same amount of work and overtime compensation likely would aid in employee retention and attracting new hires. Those employers who choose not to pay overtime essentially would need to spread the hours among their employees, resulting in more consistent work hours for many aides. Moreover, any extra wages earned may be used to pay for other benefits, such as health insurance coverage. As one study found, for this low-income workforce, "compensation accounts for more actual job turnover. [Therefore, h]igher wages, more hours, and travel cost reimbursement are found to be significantly associated with reduced turnover."[104] Another report determined that "increases in the federal or state minimum wage can make home care employment more desirable."[105]

For the estimated 8 to 15 percent of aides who work more than 40 hours per week, only a portion of that percentage likely provides services for the same client. Many who work overtime accrue long hours in the service of at least a few clients, traveling between client homes during the workweek. It is also conceivable that in a minority of cases, the aide provides companionship services around the clock for a stretch of a few or several days. Most, however, have been estimated to work 45 hours per week on average, not including travel time between client homes.

Provider continuity that results in overtime work, however, has drawbacks. From the aide's perspective, the long work hours can be a burden. For instance, "it cannot be denied shifts beyond the traditional 8 hours have been associated with increased risk of

[104] Morris, L. Quits and job changes among home care workers in Maine: The role of wages, hours and benefits. *The Gerontologist*, 2009, 49(5), 635-650.
[105] Burbridge, L. The labor market for home care workers: Demand, supply, and institutional barriers. *The Gerontologist*, 1993, 33(1), 41-46.

errors, incidents, and accidents."[106] Many studies have shown that extended work hours result in increased fatigue, decreased alertness and decreased productivity, negatively affecting employee health and well-being. Long work hours in the healthcare field "have adverse effects on patient outcomes and increase health care errors and patient injuries."[107] For example, nurses working more than 8 hours report more medication errors, falling asleep at work, a decrease in productivity, and impaired critical thinking abilities. The error rates double when nurses work 12.5 or more consecutive hours. A 2004 National Institute for Occupational Safety and Health report found that "12-hour shifts combined with more than 40 hours of work per week reported increases in health complaints, deterioration in performance, or slower pace of work."[108] One study that analyzed 13 years worth of data and nearly 100,000 job records notes that "long working hours indirectly precipitate workplace accidents through a causal process, for instance, by inducing fatigue or stress in affected workers."[109] It is therefore telling that "[d]irect care workers have the highest injury rate in the United States, primarily due to work-related musculoskeletal disorders."[110] One of the purposes of the FLSA's overtime pay requirement is to induce employers to hire more people to work fewer hours each. Doing so in those circumstances where excessive overtime hours are worked may therefore result in better care provided.

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[106] Keller, S. Effects of extended work shifts and shift work on patient safety, productivity, and employee health. *American Association of Occupational Health Nurses Journal*, December 2009, 57(12), 497-502.
[107] Keller, S. 2009
[108] Caruso, C., Hitchcock, E., Dick, R., et al. Overtime and extended work shifts: Recent findings on illnesses, injuries, and health behaviors. *National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services*. April 2004.
[109] Dembe, A., Erickson J., Delbos, R., *et al.* The impact of overtime and long work hours on occupational injuries and illnesses: new evidence from the United States. *Occupational and Environmental Medicine*, 2005, 62, 588-597.
[110] Zontek et al, 2009. Psychosocial Factors Contributing to Occupational Injuries Among Direct Care Workers. AAOHN Journal, 2009, Vol. 57, No. 8, 338-347. In this study, direct care workers includes nursing aides, orderlies, and attendants in any setting (institutional or residential).

Many regard having the same home care aide for long hours as a cornerstone of "continuity of care" and having more aides to cover the same number of companion hours for a client as negatively impacting quality of care. As discussed above, however, the opposite may be true. Working extended hours may affect the quality of care that the aide is able to provide and even the aide's own health and well-being. Coverage for companions under wage and hour laws may also result in improved retention and hiring, which saves the employer costs related to turnover rates; job satisfaction; and increase in pay. Attendant benefits of spreading work hours more evenly may include job stability for companions, decreased risk of fatigue, errors and work-related injuries, and better overall job performance, resulting in improved client care and outcomes.

Furthermore, it has been shown that paying employees below minimum wages, not paying for all hours worked or overtime, and providing no training or benefits is not the only path to success that an employer has in the home care industry. Another business model, in which employees receive training, an overtime wage differential, and health care benefits, has been successful. Cooperative Home Care Associates (CHCA), based in New York, for example, has always paid workers overtime. Although overtime at CHCA is carefully managed, it can still be substantial (e.g., 30 percent or more of employees exceed 40 work hours per week); allowing, even expecting overtime, permits CHCA, however, to use a staffing plan that maintains continuity of care. These policies have driven CHCA's turnover rate far below the industry average, a major factor in its financial success.[111] In terms of employee coverage, CHCA cases requiring weekday and weekend coverage are assigned permanent aides who work on alternate weekends. Also, cases requiring 24-hour coverage, seven days per week, are shared among four aides,

[111] Elsas & Powell, 2011.

requiring only some overtime hours.[112] Other agencies such as Community Care Systems, Inc., in Springfield, Illinois, have reduced overtime costs by distributing extra hours more evenly among workers through better tracking of work hours. Close monitoring of employee workloads and spreading of work hours also curbed overtime use for Illinois-based Addus HealthCare, one of the nation's largest home care employers. These employers pay overtime even in those states that do not require it, demonstrating that "wage and hour protections are economically realistic for the industry, and can be achieved without excessive use of costly overtime hours."[113] These examples suggest that requiring overtime pay in this industry does not inevitably cause disruption of employer-employee relationships and caregiver-patient relationships leading to higher turnover, discontinuity of patient care, and increased use of the grey market.

Benefits

This section describes the expected benefits of the proposed change to the companionship exemption. Potential benefits of this revision to the "companionship services exemption" flow from the transfer of regular and overtime wages to workers from their employers, and include: reduced worker turnover, reduced worker injury rates, and decreased worker reliance on public assistance programs.

Transfer Effects

Perhaps the most significant effect of the proposed rule is the transfer of income from businesses and their owners to workers, and potentially, from one group of workers to another group of workers. In economics, a transfer payment is broadly defined as a redistribution of income in the market system that does not affect output.

[112] NELP report, page. 26.
[113] NELP report, page 25-26.

Transfer Effects Associated with Minimum Wage and Travel Provisions

The proposed rule leads to an unambiguous transfer from employers to employees in those states that currently do not require agencies to pay minimum wage to employees who provide this type of home health care services. Similarly, payment for travel time is also an unambiguous transfer of income from businesses and their owners to workers. These are estimated to be approximately $39.7 million. In addition, the $3.1 million in minimum wage payments to independent providers directly employed by families represent an unambiguous transfer from families to caregivers.

Two factors could change the dynamics of this transfer scenario. First, increased wages and travel cost might be passed through to patients in the form of higher prices for home health care services. If those higher prices result in patients finding alternatives to home health care services (e.g., accessing the grey market for services or institutionalizing the patient), then the income transfer through travel and overtime pay is partially offset because the provision of home health services is reduced, resulting in, reduced revenues to agencies, and the deadweight loss to the economy. This reduction in demand by households will be less pronounced if the demand for home health care services is inelastic (i.e., the hours of home health care services purchased does not change when price increases), as assumed in this analysis. The Department believes the market response to the proposed rule will be relatively small, but did not estimate the response due to lack of information.

Second, the Department expects that over time some of these costs may be reimbursed to agencies through increased Medicare and Medicaid payments. To the extent that

Medicare and Medicaid increase reimbursement rates to cover these costs, the transfer is from the federal and state agencies to workers.

Transfer Effects Associated with Overtime Provisions

The transfer of income associated with the payment of the overtime differential is more ambiguous. Employers are likely to respond to overtime pay requirements along a spectrum ranging from (1) banning all overtime and spreading hours to other workers or hiring new workers to fill the available hours, to (2) maintaining current staffing patterns and paying overtime for all work hours exceeding 40 per week. To the extent that employers choose to pay overtime, the income transfer is from businesses and their owners to workers. However, to the extent that employers eliminate overtime and spread the now available hours to other employees or new hires, the transfer is from worker to worker. Employees who used to exceed 40 hours of work per week will work fewer hours, transferring income to fellow workers who will absorb the extra hours. It is also possible that those employees working greater than forty hours may distribute those hours among multiple employers.

Potential Macroeconomic Impacts of Transfer Effects

In the first year, the proposed rule is expected to transfer $42.8 million in income from businesses and families to home health care workers due to minimum wage and travel time pay requirements. Up to $139.3 million more might be transferred in the first year to workers due to the overtime provisions, although the total amount transferred, and the percent transferred from owners versus other workers depends on how owners modify staffing plans in response to the rule.

Because employees in this industry earn on average hourly wages of approximately $10.14, it is reasonable to assume that a high percentage of the extra income would be spent by the employees and their families. The percent spent of each additional dollar earned is the marginal propensity to consume (MPC) out of income. It is also reasonable to assume that the MPC for these employees is higher than the MPC of their employers; for example, employees might spend $0.90 of each additional dollar earned, while their employers, with significantly higher incomes, might spend only $0.50 of each additional dollar earned. Thus, the transfer of income from employers to employees is likely to result in increased aggregate consumption because of employees' higher MPC.

The additional consumption might stimulate the economy an amount that exceeds the initial expenditure through the multiplier effect (e.g., the increased purchases by home health care workers generate additional income for those businesses, whose owners then increase their own spending). Moody's Economy.com model suggests the multiplier effect for low-income consumers ranges from 1.64 for income associated with food stamps to 1.73 for income from unemployment benefits.[114] Thus, $1 of food stamps given to low income consumers increases GDP by $1.64 dollars.

The key unknowns in estimating any multiplier effect associated with the proposed rule include:

- Estimating income transfers strictly from employers to employees, excluding transfers from one group of employees to another group of similar employees.
- The difference between the MPC of employers and employees; the Department was unable to find estimates of MPC by annual income.

[114] Nallari, R. Re-thinking Fiscal Mulitpliers. World Bank. Growth and Crisis Blog. April 20, 2010. Accessed at: http://blogs.worldbank.org/growth/re-thinking-fiscal-multipliers.

- The size of the multiplier.

The Department did not estimate the multiplier effect due to the uncertainty associated with key variables and parameters for the calculation.

Reduction in Employee Turnover Rates

Researchers have found that lower wages are associated with higher turnover and lower quality of care, and that increases in wages for home health care workers result in decreased turnover rates. Excessive employee turnover is costly to businesses, and as mentioned earlier, studies have found turnover rates in the home health care industry range from 44 to 95 percent per year, and even approach 100 percent per year. [115]

Frequent turnover is costly for employers in terms of recruitment costs and training of new aides and also in terms of the likelihood of a reduction in the quality of care or not being able to provide care at all. The employee turnover rate in this industry is high because of low wages, poor or nonexistent benefits, and erratic and unpredictable hours. Job satisfaction, and the desire to remain in a given position, is highly correlated with wages, workload, and working conditions. Increased pay for the same amount of work and overtime compensation likely would aid in employee retention and attracting new hires. Those employers who choose not to pay overtime essentially would need to spread the hours among their employees, resulting in more consistent work hours for many aides.

Decreasing the rate of employee turnover may result in significant cost savings to employers. For example, an agency employing 50 workers with a turnover rate of 35 percent replaces about 18 workers per year. The new workers hired to replace the

[115] PHI 2010a; Zontek, T., Isernhagen, J., Ogle, B., 2009; Ashley, A., Butler, S., Fishwick, N., 2010.

workers who left must be recruited, interviewed and trained to perform the job tasks, requiring a significant investment of time and resources by the employer. If the turnover rate decreases by 10 percent to 25 percent per year, then only about 13 workers would be replaced annually.

Reduction in Worker Injuries and Illnesses

Many studies have shown that extended work hours result in increased fatigue, decreased alertness, and decreased productivity, negatively affecting employee health and well-being. A 2004 National Institute for Occupational Safety and Health report found that "12-hour shifts combined with more than 40 hours of work per week reported increases in health complaints, deterioration in performance, or slower pace of work."[116] One study that analyzed 13 years worth of data and nearly 100,000 job records notes that "long working hours indirectly precipitate workplace accidents through a causal process, for instance, by inducing fatigue or stress in affected workers."[117] It is therefore telling that "[d]irect care workers have the highest injury rate in the United States, primarily due to work-related musculoskeletal disorders."[118] The rate of days away from work (work days missed due to on-the-job injuries) for nursing aides, orderlies and attendants was almost four times greater than the all-worker rate—449 per 10,000 compared to 113 per 10,000 for all workers.[119] One of the results of the FLSA's overtime pay requirement is to induce employers to hire more people to work fewer hours each. Doing so in those

[116] Caruso, C., Hitchcock, E., Dick, R., et al. Overtime and extended work shifts: Recent findings on illnesses, injuries, and health behaviors. *National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services*. April 2004.
[117] Dembe, A., Erickson J., Delbos, R., *et al.* 2005.
[118] Zontek and Isernhagen, 2009.
[119] NELP report (p.27, FN45).

circumstances where excessive overtime hours are worked may therefore result in fewer injuries and illnesses incurred.

Reduced Reliance on Public Assistance

An increase in wages might reduce home care worker reliance on public assistance programs to meet the needs of their own households. Recent research finds that approximately 40 percent of home health care workers receive public assistance.[120] Almost 90 percent of these workers are women. [121]

Assuming these workers are in a family consisting of themselves and two children the average amount of public assistance for such families is about $10,300.[122] In addition, many minimum wage workers also receive food stamps. The federally-assisted Supplemental Nutrition Assistance Program (SNAP, previously referred to as the Food Stamp Program) provided aid to 33.5 million participants in 2009 with total expenditures of $50.4 billion, an average of $1,500 in food stamps expenditures per participant.[123] This would entail $4,500 per family for an assumed family of three. In total, the average home health services worker might receive $14,800 in public assistance and food stamps to provide for her/his family.

Increased wages should reduce demand for public assistance services resulting in a savings to these programs; however, the Department is unable to quantify the savings due to lack of data on how the benefits of these programs vary with income. The savings associated with the minimum wage provisions under the proposed rule might be small; the Department estimated that the average below-minimum wage worker would receive a

[120] PHI 2010a,, p.36
[121] PHI 2010a, p.26
[122] TANF Eight Annual Report to Congress
[123] Characteristics of Supplemental Nutrition Assistance Program Households: Fiscal Year 2009. U.S. Department of Agriculture, Food and Nutrition Service. October 2010.

raise of $0.23 per hour to reach minimum wage. If such employees work the average 35 hours per week for 52 weeks per year, their additional income will be about $400 per year. To the extent that the employees' work requires significant travel time and overtime, or added hours of work due to employer schedule adjustments, they will also receive additional income. The Department did not estimate this portion of the potential economic impact due to uncertainty about the number of workers who would receive payment for travel time or additional hours of work.

Improved Quality of Care

As has been stated previously, one of the main benefits of this proposed rule is that the professionals who are entrusted to care for the elderly, disabled, and sick in their homes will have the same protections in the labor market as almost all other employees. Guaranteed minimum wage and overtime pay for home care jobs, comparable to similar occupations, will also more likely attract more qualified workers to the home care industry, which will improve the quality of care overall. The increased availability of home care workers will allow employers to not only meet significant demand for home care services, but also spread employment, so that 1) workers are working fewer overtime hours which will result in less fatigue and more energy devoted to their clients; and 2) more workers will be serving fewer clients, which is a desire of many customers seeking home care. In addition, with the standard of pay raised, more highly trained and certified workers will seek out and remain in the HHA and PHA occupations, and a higher quality service will be provided to the client. While a monetary value cannot be placed on increased professionalism and improved care, those expected benefits are noteworthy.